

Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System

Appendix G: The Commission Proposal for Health Reform

Prepared for:

The Colorado Blue Ribbon Commission for Health Care Reform

By:

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THE BLUE RIBBON COMMISSION PROPOSAL

The Commission specified a health reform option based upon the Commission's recommendations. This option includes several features designed to expand health insurance coverage and access to health services for Colorado residents. Their proposal specifications cover a wide range of issues including expanding eligibility for Medicaid, expanding coverage under private insurance, creating new health insurance options for residents, improving Colorado's health care system, and creating sustainable financing and governance. The specifications for the Commission proposal are summarized in *Figure 1*.

Figure 1
Commission Proposal Specifications

Items Modeled	Commission Proposal Recommendations
Expand and Reform Private Health Insurance in Colorado	
√	Require all legal residents of Colorado to have health insurance coverage with basic plan coverage
√	Provide subsidies for low-income families and individuals to purchase private insurance
√	Reform the individual insurance market
	Create a Coverage Clearinghouse
√	Require all employers to create IRS Section 125 premium-only plans
√	Undocumented residents Excluded from mandate and subsidies
	Create incentives for communities with good local solutions
Expand and Reform Colorado Medicaid	
√	Restructure and expand Medicaid and CHP+
√	Restructure Medicaid and CHP+ benefits
√	Improve outreach and enrollment in Medicaid/CHP+
	Improve access to care in the Medicaid/CHP+ program
	Improve quality of care in the Medicaid program
	Increase Medicaid recipients' enrollment in private coverage
Create New Health Insurance Options for Coloradans	
Modeled Separately	Study a plan to allow employers to offer 24-hour coverage to their employees
Modeled Separately	Study a plan to create an Optional Continuous Coverage Portable Plan

Items Modeled	Commission Proposal Recommendations
Improve Colorado's Health Care System	
	Improve access to care for all Colorado residents
√	Ensure that health care providers that serve low-income and rural populations have adequate funding
√	Strengthen Colorado's local public health infrastructure
	Increase use of health information technology
	Improve end-of-life care
	Improve care coordination
	Increase transparency of cost and quality for consumers
√	Medical Home, Increased use of preventive care and promote wellness
	Support local communities that wish to improve health care outcomes
√	Reduce administrative costs
Create Sustainable Financing and Governance	
	Increase efficiency and access before expanding coverage
√	Pursue new federal funds and state tax dollars to fund new programs
	Create three new entities to govern and administer new programs

The Commission also identified other potential health reforms that merit further study. The first policy would be give people the option of enrolling in a public insurance program modeled on a single-payer system similar to the CHSP option discussed in the prior section. The second option known as “24-Hour Coverage” permits employers to fold workers compensation, health and disability insurance into a single health and disability insurance plan designed to reduce the high overhead costs for existing workers’ compensation programs.

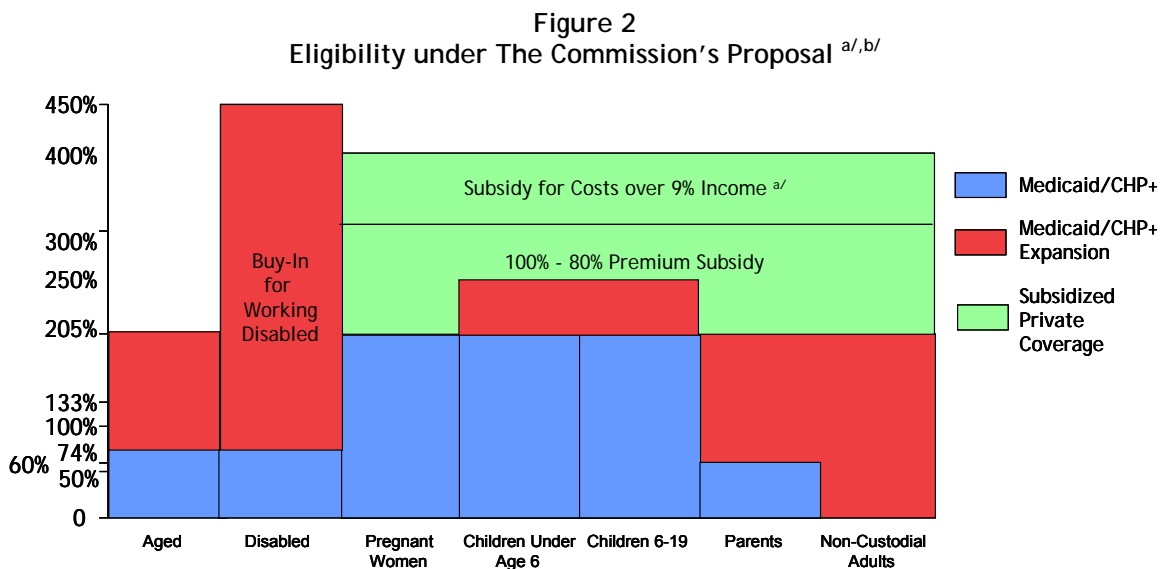
We present the study of the Commission’s proposal in the following sections:

- Key Provisions of the Commission’s Proposal;
- Key Assumptions;
- Cost and Coverage Impacts;
- Ten-Year Cost Projections;
- 24-Hour Coverage; and
- The Optional Continuous Coverage Portable Plan

A. Key Provisions of the Commission Proposal

Below we present the key provisions of the Commission's proposal to expand and reform the Medicaid program as well as private health insurance in the State, create new health insurance options for residents, improve Colorado's health care system, and create sustainable financing and governance.

Figure 2 illustrates Medicaid eligibility expansion and subsidized coverage under the Commission's proposal. All legal residents, including citizens and legal non-citizens would be eligible for the Medicaid/CHP+ program as well as the subsidies.



a/ Does not include existing home and community based services waiver program eligibility, which is available to aged and disabled people below 225% FPL who would otherwise need nursing home services.

b/ Does not display proposed medically needy program to 50% FPL or the proposed medically correctible program.

c/ Coverage for aged expansion group includes only payments for Medicare Part-B premium, coinsurance and deductibles and full Medicaid benefits for those aged who do not qualify for Medicare.

d/ Does not display full-cost Buy-in for disabled above 450 percent of the FPL.

Source: The Lewin Group

The proposal expands Medicaid/CHP+ for children up to 250 percent of the FPL. It expands eligibility for non-custodial adults (including the aged) and parents up to 205 percent of the FPL. In addition it expands eligibility for disabled adults up to 450 percent of the FPL through a buy-in.

The proposal provides subsidies for people up to 400 percent of the FPL for private coverage. People with incomes up to 300 percent of the FPL receive a sliding-scale subsidy for a comprehensive benefits package modeled on the CHP+ benefits package. People with incomes between 300 percent and 400 percent of the FPL receive a subsidy for the cost of a minimum benefits package in excess of 9 percent of their income. A detailed description of each of these expansions is presented below.

1. Expand and Reform the Private Health Insurance Market in Colorado

The Commission proposal mandates health coverage in a basic plan, provides subsidies to low-income people, makes changes in the private market to improve access to insurance and creates a clearinghouse from which individuals can obtain information about health insurance options and become covered. In addition, the Commission would mandate that employers set up section 125 premium-only plans for their workers. The Commission does not make any change to how undocumented residents in Colorado are currently covered. Finally, the Commission proposes to create incentives for communities with good local solutions to getting people coverage. These incentives have not yet been defined by the Commission. The Commission's recommendations are presented in more detail below.

a. Require all Citizens and Legal Residents to Have Basic Coverage

The mandate applies to all citizens and legal residents. All legal non-citizens are also eligible for the Medicaid/CHP+ combined program and premium subsidies as discussed below. To satisfy the insurance mandate, people are required to purchase at least a basic health plan. For modeling purposes, we used the benefits package proposed under the Better Health Care for Colorado plan with a limit on benefits of \$50,000. These benefits are summarized in *Figure 3*.

Figure 3
Minimum Benefit Plan to Comply with the Individual Mandate^{a/}

Covered Benefits/Services	Copayments
Physician Services	\$10
Primary Care (includes adult prevention and monitoring a chronic condition)	
Specialist Care	\$20
Urgent Care	\$25
Outpatient Hospital	
Surgical Services	\$50
Other Outpatient Services	\$25
Ambulance (emergency)	\$50
Laboratory & X-Ray	\$0
Family Planning Services	\$0
Mental Health Services ^{a/}	Parity
Therapies (consistent w/HMO benefit)	\$10
Inpatient Hospital Services	\$100
Emergency Services	\$50*
Durable Medical Supplies/Equipment	\$50
Prescription Drugs (Medicaid FFS carve-out, if broad-based PDL is implemented)	Generic-\$5, Brand -50%, \$25 minimum
Annual Benefits Limit	\$50,000

a/ Requires mental health parity (i.e., covered to the same levels and restrictions as other medical services).

b/ This benefits package is eligible for the 9 percent of income cap for people between 300 percent and 400 percent of the FPL.

Source: Modified from the Better Health Care for Colorado proposed benefits package.

Figure 4 shows our actuarial estimates of premiums for the Minimum benefits package for single and family coverage by the age and gender of the policyholder. These include the cost of benefits and administration of insurance.

Figure 4
Monthly Premiums (PMPM) for the Minimum Benefits Package under the Commission's Proposal by Age, Gender and Tier: Contracts Effective 2007/2008 ^{a/}

	Overall Population Average ^{b/}		Individual Market Only Premiums ^{c/}	
Age/Gender	Single	Family	Single	Family
Under age 25 Male	\$145.23	\$524.68	\$85.98	\$309.66
25 - 34 Male	\$177.53	\$764.86	\$105.10	\$451.42
35 - 44 Male	\$234.77	\$913.18	\$138.99	\$538.96
45 - 54 Male	\$394.14	\$1,026.96	\$233.33	\$606.11
55 - 64 Male	\$669.74	\$1,226.76	\$396.49	\$724.03
Under age 25 Female	\$259.42	\$558.93	\$153.11	\$329.88
25 - 34 Female	\$326.63	\$789.07	\$192.78	\$465.71
35 - 44 Female	\$380.01	\$874.64	\$224.28	\$516.21
45 - 54 Female	\$500.97	\$1,033.84	\$295.67	\$610.17
55 - 64 Female	\$720.81	\$1,269.40	\$425.42	\$749.20

a/ Based upon the Better Health Care for Colorado benefits package using a \$50,000 maximum benefits limit. Premium estimates differ from our estimates for that proposal because: we assume a \$50,000 benefits limit under the Commission's proposal while Better Health Care for Colorado assumes a \$35,000 benefits limit; and, the Commission's proposal uses commercial provider payment rates while the Better Health Care for Colorado proposal used Medicare provider payment rates.

b/ This is the overall average cost of the benefits package including both the CoverColorado population and people who would remain in the individual non-group market.

c/ Includes only those participating in the non-group market (i.e., excluding CoverColorado).

Source: Lewin Group estimates using cost and utilization data supplied by NovaRest Consulting.

The mandate would be enforced by:

- Requesting proof of coverage at school enrollment;
- Requesting proof of coverage at Department of Motor Vehicles;
- Assessing penalty at tax filing without proof of coverage, equal to the cost of a year's coverage;
- Creating central registry of uninsured; and
- By referring those who file an income tax return without proof of coverage to the Coverage Clearinghouse

In addition, the program would automatically enroll people eligible for a full-subsidy program through food stamps, other income-tested programs and tax filing. People living between 400 percent and 500 percent of the FPL would be exempt from the mandate if they do not have

access to a basic benefit plan that is less than 9 percent of their income. In addition, an exception process based on individual circumstances will be created.

b. Subsidies for Private Insurance to Low-income Families and Individuals

The program would provide subsidized coverage for all uninsured families and individuals with incomes between 205 percent and 400 percent of the FPL. For those between 205 percent and 300 percent of the FPL, the benefits package that qualifies for the premium subsidy is based upon the CHP+ benefits package modified to cover services for adults (*Figure 5*).

Figure 5
Benefits Package that Qualifies for the Premium Subsidy Program Between 205 Percent and 300 Percent of FPL

	Based on the CHP+ Benefits Package
Coinsurance/Co-pays	Co-pays based on sliding scale and family size, generally: No co-pays for preventive care including check-ups, shots, teeth cleanings and dental x-rays; \$1-\$5 per visit for medical care; \$3-\$15 for urgent and emergency care; and \$5 per procedure for fillings and extractions.
Lifetime Benefits Maximum	No limit
Services	
Emergency Services	\$3 or \$15 co-pays
Emergency Transportation	Covered in full
Inpatient Hospital Stay	Covered in full
Outpatient Ambulatory Surgery	Covered in full
Lab, x-ray and Diagnostic Tests	Covered in full
Medical Office Visit	\$1-\$5 per visit
Preventive Services	Covered in full
Maternity Care	Covered in full
Neurobiologically Based Mental Illness	\$1-\$5 per visit
Other Mental Health Services	\$1-\$5 per visit_Limits: 45 inpatient days or 90 outpatient treatment days per benefit period. 20 outpatient visits.
Alcohol and Substance Abuse Treatment	\$1-\$5 per visit Limits: 20 outpatient visits per diagnosis. No inpatient coverage.
Physical, Occupational and Speech Therapy	\$1-\$5 per visit Limits: 30 outpatient visits per diagnosis.
Durable Medical Equipment	Max \$2,000, excluding glasses contacts or hearing aids.
Prescription Drugs	Generic: No co-pay Name brand: \$5 co-pay

	Based on the CHP+ Benefits Package
Vision Services	\$1-\$5 per visit limits: Coverage of age-appropriate preventive and specialty care. \$50 benefit for lenses, frames or contacts.
Audiological Services	Age appropriate preventive care, hearing aids max \$800
Transplant Services	Coverage for limited transplants with prior authorization
Dental Care	\$5 co-pays per procedure for fillings and extractions; Annual max \$1,000; Coverage for cleanings, exams, x-rays, fillings, root canals.
Podiatry Services	Excluded
Skilled Nursing Facility	Covered in full
Hospice Care	Excluded
Home Health Care	Covered in full
Spinal Manipulation	Excluded

Source: Child Health Plus Program.

Our estimated premiums for this benefits package are presented in (*Figure 6*). We assumed the following subsidy schedule:

- Up to 250 percent of the FPL – 100 percent subsidy of the premium subsidy benefit package, or the employee share of an equivalent employer benefit package; and
- Between 250 percent and 300 percent of the FPL – 80 percent subsidy of the premium subsidy benefit package, or the employee share of an equivalent employer benefit package.

The subsidy applies to people purchasing individual coverage and the employee share of premiums in employer plans for only those people who did not have coverage for six months prior to entering the program. The following constraints would apply:

- To receive a subsidy, an individual must have been uninsured for at least six months, e.g. a six month waiting period;
- People are required to enter into their employer's plan with a state subsidy if the employer coverage is equivalent to or more comprehensive than the CHP+ plan coverage; and
- There would be an assets test equal to \$100,000 minus car, home, qualified retirement and educational accounts and disability-related assets.

The program also includes premium subsidies for those with incomes between 300 percent and 400 percent of the FPL. The subsidy covers the cost of the premium in excess of 9 percent of income for the minimum benefits plan described above. As discussed below, the state would pursue federal funds for the premium subsidy program through a Medicaid 1115 waiver.

Figure 6
Monthly Premium for CHP+ Benefits Package PMPM by Age, Gender and Tier:
Contracts Effective 2007/2008 ^{a/}

Age/Gender	Monthly Premium per Enrollee	
	Single	Family
Under age 25 Male	\$167.27	\$604.25
25 - 34 Male	\$204.45	\$880.84
35 - 44 Male	\$270.38	\$1,051.65
45 - 54 Male	\$489.46	\$1,182.67
55 - 64 Male	\$771.30	\$1,412.78
Under age 25 Female	\$298.88	\$643.68
25 - 34 Female	\$376.16	\$908.72
35 - 44 Female	\$437.63	\$1,007.26
45 - 54 Female	\$576.92	\$1,190.59
55 - 64 Female	\$830.10	\$1,461.86

a/ This estimate assumes that none of those between 200 percent and 300 percent of the FPL are permitted to enroll in CoverColorado.

Source: Lewin Group estimates using cost and utilization data supplied by NovaRest Consulting.

c. Reform the Individual Insurance Market

People living above 300 percent of the FPL would be required to obtain at least the basic benefit package described above. People with chronic health conditions who apply for individual coverage would be required to participate in an expanded CoverColorado program (i.e., high risk pool). All others would be eligible to buy coverage in the non-group market on a guaranteed issue basis with modified community rating. The subsidies for the minimum benefits package for those between 300 percent and 400 percent of the FPL would be available for both CoverColorado and non-group market coverage. These changes to the individual market include:

- Guarantee issue all individual products, including the basic benefit plan to all people who do not meet the new criteria for CoverColorado. Enrollees who develop one of the conditions after enrolling will not move to CoverColorado;
- New CoverColorado criteria will be developed to identify people with chronic conditions. These criteria will be developed by a broad-based group; and
- We assumed a list of chronic conditions that typically result in high costs.

CoverColorado premiums will be the same as the individual market at 100% of standard rates. Rates would be set by looking at rates for similar plans of the five largest individual carriers in Colorado. Benefit packages will include a basic plan and a comprehensive plan, similar to packages offered in subsidy programs and the Coverage Clearinghouse. CoverColorado would

be available to only those who are not eligible for Medicaid/CHP+ or the premium subsidy program for people below 300 percent of the FPL.

All individual policies will be rated based on age and geography, similar to the small group market. Existing guaranteed renewability will remain in place. Rules would be developed to discourage people from shifting markets when their circumstances change; e.g. people waiting until they are sick to buy comprehensive coverage.

The program creates a minimum benefits package. As discussed above, we assumed that this benefits package would be the same as the benefits package created under the Better Health Care for Colorado program, with a cap on benefits of \$50,000 per year. The plan would be the minimum level of benefits that will satisfy the individual mandate. The plan would be designed to have the following features:

- The package would be designed to cost approximately \$200 per person per month;
- The basic benefit plan would have an HSA option as well as delivery system options (HMO, PPO, etc);
- The basic benefit plan would offer mental health benefits on par with the physical health benefits offered;
- Every insurance company that sells health insurance in Colorado will be required to offer these individual plans, appropriate to their type of network; and
- Limits on mental health, therapies, and prescription drugs would be discouraged.

The proposal would create a process for annual review of the minimum benefits plan. It would be implemented through a multi-stakeholder group and would be insulated from the political process. The objective would be to create a minimum benefit package that is “transparent, participatory, equitable, compassionate, sensitive to value, flexible and responsive.”

d. Require all Employers to Create IRS Section 125 Premium-only Plans

The Commissions proposal would require all employers to create IRS Section 125 premium-only plans for their employees. The employer would then withhold premium payments from the worker’s pay. This structure would have the effect of making the full-amount of the worker’s premium payment in pre-tax dollars, thus partially offsetting the cost of coverage for the employee. The state would develop standards that make it easier for Colorado employers to set up these plans.

The proposal also requires all employers who do not offer coverage to refer employees to the Coverage Clearinghouse for information on insurance. In addition, employers would be asked to distribute information and help people sign up for subsidies.

2. Expand and Reform Colorado Medicaid

The Commission’s proposal combines Medicaid and CHP+ into a single program for all eligible populations except the aged, disabled and foster children. It expands the program to cover children in higher income groups, parents of eligible children and childless adults, and creates a

Medicaid-like state-funded program for legal non-citizens. In addition, it establishes several options for expanding coverage for disabled individuals and restructures the Medicaid benefits package to provide more covered services, with particular attention to preventive services and case management services. The proposal also creates mechanisms to improve outreach, enrollment and access to services. In addition, the proposal recommends ways to improve quality of care in the program and coordination of benefits. The Commission's Medicaid and CHP+ specifications are presented in more detail below.

a. Expand Eligibility for Medicaid and CHP+

As discussed above, the proposal expands the Medicaid/CHP+ program for parents, childless adults and children. It also provides subsidies for private coverage. All Colorado citizens and legal immigrants below 205 percent of the FPL would be eligible for the expanded Medicaid/CHP+ program and the subsidies.

Increases in income eligibility levels: These expansions in eligibility include:

- Children: Eligibility to CHP+ is increased to 250 percent of the FPL;
- Families with children: eligibility is expanded to 205 percent of the FPL;
- Childless adults: the program would expand eligibility to childless adults with income below 205 percent of the FPL;
- Elderly non-Medicare eligible: The program would cover aged non-Medicare eligible people who are under 205 percent of the FPL; and
- Elderly Medicare eligible: Aged people eligible for Medicare with incomes below 205 percent of the FPL would be covered for Medicare premiums and Medicare co-payments.

The program includes the following eligibility requirements:

- Require three-month waiting period for these expansion populations;
- Implement a new asset test for newly eligible parents and childless adults equal to \$100,000 minus car, home, qualified retirement and educational accounts and disability-related assets; and
- We assumed that policies will be put into place that will maintain SSI/SSDI coverage for people with disabilities at current levels.

Medicaid Look-alike for Excluded Legal Non-citizens: In addition, the Commission proposes to create a Medicaid look-alike program to cover low-income legal non-citizens who are not already covered by Medicaid. Under federal law, these individuals are excluded under the existing Medicaid/CHP+ programs if they have been here for fewer than 5 years. Under this proposal, legal non-citizens who have been in the US for fewer than 5 years would be eligible for Medicaid subject to the same income and assets requirements that apply to others. Because federal law prohibits federal matching funds for this population, this would be a "state-only" program paid entirely by the state.

Medically Needy Program: The state would exercise its option under the current Medicaid program to implement a “medically needy” program. Under this program, people with incomes in excess of program eligibility levels may still enroll and receive Medicaid benefits if their income is substantially consumed by health care costs. To qualify, the program would compute the individual’s income and subtract from it their health expenditures for the month. If income less medical expenses brings them below 50 percent of the FPL, the individual is considered to have “spent-down” to the level where they are eligible. The program would cover costs beyond the 50 percent of FPL level.

Medically Correctible Program: The Commission proposes to establish a “medically” correctible program. Under this program, the state would pay for non-medical items in cases where this one time expenditure was highly likely to result in substantial long-term savings to the state. This can include items such as air conditioners that enable certain disabled people to continue to live at home and/or maintain a job. The program would be for:

- People for whom this one time expenditure would mean the difference between going back work or not; and
- People who could use this to keep them out of or move them out of institutional care.

The Commission proposes to provide funding for this program of \$5.0 million per year.

Medicaid Buy-in for the disabled: The Commission proposes to establish a subsidized Medicaid buy-in for adults with disabilities. The program would be available to adults who meet SSI disability criteria and have income below 450 percent of the FPL. There would be no assets test. Premiums for the buy-in would be determined based upon the average cost of care for disabled people in the program. The premium that the individual would pay would be computed as follows:

- Disabled between 200 percent and 300 percent of the FPL: 4.5% of income;
- Disabled between 300 percent and 400 percent of the FPL: 5.5% of income;
- Disabled between 400 percent and 450 percent of the FPL: 7.0% of income

Also, disabled people with incomes above 450 percent of the FPL would be able to enroll by paying the full amount of the premium.

Home and Community Based Services (HCBS) waivers: The Commission proposes to fund waivers for people with developmental disabilities, children with autism and HCBS Children. Waivers are a process created by Congress that allow the state to petition waivers from the federal government to relax some of its rules in order to provide specialized benefits to the disabled population. These waiver proposals include: ¹

¹ The total dollar amounts and the number of slots specified were provided as part of the final recommendations from the Commission. The Home and Community Based Waivers are not an entitlement. The number of individuals that can be served in any given year must be approved by the federal government. “Slots” represent additional number of people to be served for each waiver, under the proposal.

- Add 8,204 slots to DD waivers: \$147.88 million (state and federal dollars). The term “DD waivers” refers generally to all waivers that serve persons with development disabilities. These include several independent waivers to provide services for people with developmental disabilities, specified in *Figure 7*.
- Add 500 slots to Children’s HCBS waivers: \$14.51 million (state and federal dollars); and
- Add 686 slots to the Child Autism waiver: \$17.15 million (state and federal dollars)

Figure 7
Development Disabilities Waivers

DHS waivers	FY 06-07 Funding	# Resources Covered	Ave Cost*	Wait List	Wait List Cost	State Costs Only	Federal Costs
Adult Comp	\$230,612,099	3,828	\$60,243	1,308	\$78,798,492	\$39,399,245.75	\$39,399,246
Adult SLS	\$59,910,028	3,572	\$16,772	2,438	\$40,890,439	\$20,445,219.52	\$20,445,220
Early Intervention	\$12,578,731	2,072	\$6,071	8	\$48,567	\$24,283.26	\$24,283
CES	\$8,063,282	395	\$20,413	73	\$1,490,176	\$745,088.08	\$745,088
Family Support Services	\$7,162,211	1,176	\$6,090	4,377	\$26,657,311	\$26,657,311	\$0
Total	\$319,207,655	11,043		8,204	\$147,884,984	\$87,271,147	\$60,613,837

Source: Colorado Blue Ribbon Commission for Health Care Reform, November 18, 2007

b. Restructure Medicaid and CHP+ Benefits

The Commission proposes to combine Medicaid and CHP+ into a single program for parents, childless adults and children. Parents, childless adults and children would be covered through a delivery system similar to that in CHP+, which is based upon both a managed care and managed FFS network. The existing Medicaid program for the aged and disabled would be separate and would remain largely the same as it is today. However, physician payment rates would be increased to 75 percent of Medicare payment levels for the disabled, aged, and foster care children. The Medicaid/CHP+ benefits also would be expanded as follows:

- Reduce standard Medicaid benefits to CHP+ package but include EPSDT preventive services as part of the standard package;
- Provide all children with EPSDT wrap around services and make it easier to trigger EPSDT services (including substantial outreach, additional staff, provider education, ease of approval, etc.);
- Provide adults with a trigger for wrap-around services, particularly for mental and additional dental benefits; and
- Medicaid benefits, excluding nursing home, for all Medicaid/CHP+ expansion populations.

The proposal would also provide additional services to the Medicaid populations. These include:

- An adult dental care benefit of up to \$1,000 per year;
- Remove prior authorization for medically-necessary over-the-counter medical products under \$100 (Due to lack of data, this recommendation was not modeled);
- Medical home services, including care management and care coordination;
- Targeted case management services (to collocate social worker services in primary care offices);
- Elimination of copayments for preventive and chronic care management; and
- Telemedicine for recipients in geographically underserved areas.

c. Improve Outreach and Enrollment in Medicaid/CHP+

The Commission proposes to increase participation in the existing Medicaid and CHP+ programs by simplifying eligibility and enrolling people through other income-tested programs such as the Food Stamp program. These changes include:

- Create a “Fast Track” eligibility mechanism where Medicaid/CHP+ eligible people who do not have coverage are automatically enrolled in the program by coordinating with other income-tested programs such as Food Stamps, the Women Infants and Children (WIC) program and the Free and Reduced Price School Lunch program;
- Provide one-year of continuous eligibility for Medicaid/CHP+ enrollees, as CHP+ enrollees currently receive;
- Provide presumptive eligibility for all Medicaid/CHP+ enrollees (Medicaid child presumptive eligibility already exists);
- Create a single state-level entity for determining Medicaid/CHP+ eligibility – instead of current multiple county-level systems (not modeled);
- Increase the number of provider offices that can conduct eligibility determination (not modeled); and
- Improve navigation of Medicaid eligibility and create expedited eligibility (not modeled).

3. Reduce Health Care Administrative Costs

The Commission proposes that the state take measures to standardize and simplify administrative functions for hospitals and physicians. These include standardization of required claim form attachments, coverage verification rules and credentialing requirements. As discussed below, we estimated the savings resulting from a series of administrative simplification provisions included in the Commission’s recommendations. These include:

- The Commission’s proposal requires all health plans to use standardized ID cards that conform to ANSI and WEDI standards and require all ID cards to use magnetic strips that conform to WEDI standards. This is designed to facilitate the process for physicians to use in verifying coverage;

- Requires payers to conform to uniform standards for electronic eligibility and coverage verification; and
- Support current state law for payers to indemnify providers who provide services in reliance on coverage information provided by payers that later proves to be inaccurate.

The Commission also proposes to streamline the credentialing process across health plans and other entities that credential to simplify and reduce the cost of providers obtaining certification to meet plan standards. This includes:

- Requiring the use of a standard electronic credentials application in lieu of Colorado paper application;
- Select a single credentials verification vendor for the state and require its use by all health plans; and
- Fund the verification process through user fees for all entities that credential health professionals

While nearly all health plans already use standardized claims forms, plans often require attachments that vary by health plan. The Commission proposes to standardize these claims attachments. This step includes:

- Create an antitrust safe harbor to allow plans to agree on common rules and standards for claims attachments;
- Involve providers in creation of these rules;
- Include requirements that payers accept electronic attachments that conform to standards; and
- Require all plans to conform to those rules and standards.

The Commission also proposes several steps to reduce the process required to obtain prior authorization for health care tests and procedures, including standardization of prior authorization procedures, including those of Medicaid. The Commission also proposes to establish a standardized and simplified appeals process for all carriers, including Medicaid.

4. Pursue Federal Funds

The Commission proposes to seek a Medicaid 1115 waiver to obtain federal matching funds for the expansions in Medicaid eligibility and the premium subsidy program. A waiver would be sought for the following:

- Covering childless adults under Medicaid up to 205 percent of the FPL;
- Providing subsidies to purchase private coverage for people between 205 percent and 300 percent FPL;
- Providing subsidies to purchase private coverage for people between 300 percent and 400 percent of the FPL who face premiums in excess of 9 percent of family income; and

- Cost of restructuring the Medicaid and CHP+ program.

5. *New State Tax Revenues*

The Commission proposes several taxes to raise the revenues required to fund the state share of the program. These include:

- Increase tobacco from \$.84 per pack to \$2.00 per pack;
- Increase alcohol tax:
 - On spirits from \$.60 per liter to \$5.63 per liter; and
 - On wine from \$.07 to \$.66 per liter.
- Implement a tax of 5 percent on salty snacks and soda;
- Increase the state income tax rate as needed to fully fund the state share of the program;
- Possibly increase funds from insurer assessments to fund CoverColorado; and
- If additional funds are needed, provider taxes (clinics, hospitals, nursing homes, physicians) may also be considered.

None of these funds should be used to replace existing health care funding.

6. *Create New Health Insurance Options for Coloradans*

The Commission recommends that the state study the feasibility of adopting two policies to create new health insurance options for Colorado residents. Later in this report, we present an initial analysis of these options. These include:

- **24-Hour Coverage:** The Commission proposes a study be commissioned to create a policy that would allow employers to combine workers' compensation with employer health benefits (referred to as 24-hour coverage). At the Commission's request, the analysis of this recommendation is provided separately and not integrated into the overall Commission proposal results.
- **Optional Continuous Coverage Portable Plan:** The Commission recommends that the state study establish an option for individuals to obtain health insurance coverage. At the Commission's request, our analysis of this recommendation is provided separately and is not integrated to our analysis of the Commission's overall proposal.

B. Key Assumptions

The Commission's proposal would require all Colorado residents including citizens and legal non-citizens to have health insurance coverage. It would restructure and expand eligibility for the Medicaid and CHP+ programs for the aged and disabled, parents and children. It also provides subsidies for the purchase of private insurance to all people living below 300 percent of the FPL who are not otherwise eligible for Medicaid/CHP+. In addition, it reforms CoverColorado, the state's high-risk pool, and establishes an insurance clearing house where individuals and small businesses purchase health insurance, including the minimum benefit

plan established under the proposal. In this section, we describe the methods and assumptions used to simulate the impact of this proposal. A detailed discussion of the model is presented in *Appendix H*.

1. Medicaid and CHP+ Coverage Expansion

We used the Health Benefits Simulation Model (HBSM) described previously to estimate the number of newly eligible people who would enroll in the program based on the Colorado subsample of the Current Populations Survey (CPS) data for 2004 through 2006. These data provide information on income and insurance coverage for a representative sample of the state's population that is suitable for use in estimating the number of people who are eligible for public coverage expansions.

a. Simulation of Eligibility

The model uses the income and family structure data reported in the CPS and MEPS data used in HBSM to identify those who are already eligible for the program. These individuals are subject to outreach and automatic enrollment provisions designed to increase enrollment among eligible groups. The model then uses these data to identify people who are newly eligible under various expansions in eligibility. The methods used to estimate the number of newly eligible people under the proposed Medicaid and CHP+ expansions are summarized below:

- **Income Eligibility Expansions:** HBSM uses the CPS data to identify people who are eligible for the current program and under the expanded program. The model identifies eligible groups based upon the incomes reported in these data and family relationship characteristics such as parents, children and non-custodial adults;
- **Non-citizens:** The CPS indicates citizenship status and the number of years since entering the country. We randomly allocate a portion of these individuals to undocumented status based upon Bureau of the Census and other estimates of the size of this population. Legal non-citizens who have satisfied the waiting period requirement for eligibility (i.e., residents in the US at least 5 years) are identified and counted as eligible under current law, subject to income eligibility status. Legal non-citizens who have been in the country for less than 5 years are then potentially eligible for coverage as state-only beneficiaries who are ineligible for federal matching funds. Undocumented residents are not eligible for income-based expansions under the Commission's proposal;
- **Disabled:** The model identifies people who have a disability by income level using the data reported in the CPS for these individuals. Disability is discerned from three questions in the CPS concerning reasons for not working and major activity. We assume that these individuals potentially meet the disability definition under the program. However, these individuals are included in the expansions for parents and other non-disabled adults where eligible, reflecting that there is no need to demonstrate disability if they are otherwise income eligible;

- Medically Needy: HBSM simulates eligibility using MEPS health expenditure data used in the model. These data enable us to simulate eligibility by subtracting monthly health spending from income. This enables us to identify those who “spend down” to 50 percent of the FPL and the amount of spending that would be covered under the program.

b. Simulation of Voluntary Enrollment

Once eligible people are identified in the data we simulate the decision to enroll. We first model voluntary enrollment. We then overlay the effects of automatic enrollment provisions under the Commission’s proposal. Key enrollment assumptions include:

- We estimated the number of people who would be eligible to enroll under these eligibility expansions using the income and demographic data reported in the CPS and the income eligibility levels used in the state. Estimates were developed using a simulation of month-by-month eligibility, which permits us to account for part-year eligibility;
- We simulated enrollment for eligible people based upon a Lewin Group analysis of program participation rates under the current Medicaid and CHP+ programs. This approach results in participation rates of about 73 percent for uninsured people and 39 percent for people who currently have insurance from some other source;
- We assumed that children who are currently eligible for Medicaid or CHP+ who are not enrolled would become covered under the program if one of their parents becomes covered under the private insurance subsidy program created for adults;
- We assume that people who are currently eligible for, but not enrolled in the existing Medicaid and CHP+ program would enroll due to the mandate only if they file taxes in the year. Others are assumed to be beyond the reach of enforcement; and
- Our participation model simulates “crowd-out” (i.e., the substitution of public for private coverage) based upon enrollment of children eligible for the pre-SCHIP poverty level expansions under Medicaid. The model indicates that without anti-crowd-out provisions, up to 39 percent of newly eligible people with employer coverage would eventually shift to the public program;²

We simulate enrollment under the buy-in for disabled people using the same methodology that we use to simulate enrollment in premium subsidy programs (discussed below). This is because the premium subsidy model calibrates for the fact that the program would require at least some premium payment which affects enrollment levels.

We assumed that administrative costs for Medicaid and CHP+ were assumed to equal average administrative costs for eligibility functions per enrollee under the current programs (about 5.7 percent of benefits costs).

² Crowd-out is substantially reduced by requiring in the Commission’s proposal by adopting anti-crowd-out provisions such as a six-month waiting period.

c. Automatic Enrollment and Simplification of Application Process

The Commission's proposal would adopt an "express lane" enrollment process. Under this approach, the state is permitted to enroll Medicaid and CHP+ eligible people who have been certified for benefits under other income-tested programs such as Food-Stamps, the Women and Infant Children (WIC) program and subsidized school lunch programs. These people are assumed to be presumptively eligible until eligibility can be verified.

Our analyses of data from the Survey of Income and Program Participation (SIPP) indicate that about 63 percent of uninsured children and about 37 percent of uninsured adults are in families receiving benefits from such programs. We assume that all uninsured people who are eligible for Medicaid/CHP+ who are also covered under these programs would enroll.

The Commission also proposes to implement several changes in the application and certification process to facilitate enrollment of eligible people. These include:

- Provide one-year of continuous eligibility for Medicaid/CHP+ enrollees, as CHP+ enrollees currently receive;
- Provide presumptive eligibility for all Medicaid/CHP+ enrollees (child PE already exists);
- Create single state-level entity for determining Medicaid/CHP+ eligibility – instead of current multiple county-level systems (not modeled);
- Increase number of provider offices that can conduct eligibility determination (not modeled); and
- Improve navigation of Medicaid eligibility and create expedited eligibility (not modeled).

We estimated the impact of adopting these provisions on enrollment developed in a Lewin Group study of the impact of these approaches on enrollment. The estimates developed under that study are based upon published evaluations of the effectiveness of these approaches and comparisons across states using these methods.

We assume that per-capita costs under the program for people enrolled in these ways would be about 12.5 percent lower than for people enrolled through the existing process. We base this on an HBSM analysis of costs for the uninsured indicating that spending can be up to 25 percent less than for currently enrolled people, even after we adjust for changes in utilization once insured. This reflects that eligible uninsured people probably have not had a health condition requiring medical attention and therefore are less likely to enroll.

Our estimates of enrollment are the union of those simulated to enroll voluntarily under the various expansions and the number enrolled through these processes.

2. Restructuring of Medicaid/CHP+ Benefits

As discussed above, the Commission's proposal would restructure the Medicaid and CHP+ programs. All children, parents and pregnant woman would be covered for all services now

covered under Medicaid through health plans as under the CHP+ delivery system. The program would also add certain benefits such as adult dental services and EPSDT services for children now eligible under CHP+. Our approach was to provide an itemized breakdown on the cost of making these revisions to the benefits and delivery system for those now enrolled in the program. We then adjusted the per-capita cost amounts used to estimate the cost of covering newly eligible people to reflect these changes in benefits.

a. Transfer Medicaid to CHP+ Delivery System

The Commission proposes to combine the Medicaid and CHP+ programs for children, parents and pregnant women and cover all of these beneficiaries using a delivery system modeled on the existing CHP+ delivery system. Thus, the program would enroll this group in managed care plans similar to those now used under CHP+. Our analysis concluded that returning the Medicaid program to managed care would actually increase program costs by up to 10 percent.

Colorado formerly did have a substantial Medicaid managed care program. However, the managed care organizations (MCOs) eventually terminated their participation in the program because of low payment levels. In consultation with State Medicaid officials, we believe that MCO payment levels would need to be about 10 percent higher than current per capita costs under the existing fee-for-service program. Using this assumption, we estimate an increase in program spending of about \$63.3 million.

b. Improve Benefits for the CHP+ Population

Under the combined program, all Medicaid and CHP+ enrollees would be covered for the same services now covered under Medicaid. Co-payments for services would be the same as under the existing Medicaid program. This means that benefits would be improved for current CHP+ enrollees. These improvements include:

- CHP+ children would now become eligible for EPSDT services;
- CHP+ copayments would be reduced from \$15 per visit to the nominal co-payment levels under the current Medicaid program;
- Eliminates benefit limits for mental health and substance abuse;
- Eliminates the \$500 cap on dental care; and
- Eliminates maximum benefits for eyeglasses and medical equipment.

New services such as extended mental health and dental care would be provided by a wrap-around benefits package

We estimated the impact of adopting the Medicaid benefits and co-payments for the CHP+ population based upon an actuarial analysis of the cost of making these changes in the program sponsored by the Department of Health Care Policy and Financing.³

c. Increase Medicaid Physician Payments

The Commission proposes to increase payment rates for physician services to 75 percent of Medicare payment levels. We estimated the impact of this change by comparing physician reimbursement rates under the Colorado Medicaid program with Medicare payments for these same services in Colorado. We obtained physician payment rate data from the Department. We obtained Medicare payment rates for physician services in Colorado from the Center for Medicare and Medicaid Services (CMS).

Because there are unique codes for thousands of individual physician services, we limited our analysis to 36 separate services, which together comprise about 25 percent of all physician services. We estimated “weights” for each service code based upon national data on the distribution of physician payment across individual service codes (time did not permit us to estimate these weights from Colorado-specific Medicaid claims data). We assumed that payments for each service would be equal to the greater of: 75 percent of the corresponding Medicare payment rate; and the existing Medicaid payment level.⁴

This resulted in a weighted average increase in payment rates for these services of 5.96 percent. We assumed that all physician payments for the aged, disabled and foster children would increase by that percentage.

d. Targeted Case Management

The proposal includes a targeted case management benefit for all of those enrolled in Medicaid and CHP+. The benefit is designed to assist clients with non-medical issues such as arranging housing and meeting other social needs. We estimate the cost based upon the cost of providing similar services under the CCHAP program.⁵ Using this assumption, we estimate that the program would cost about \$2.25 per beneficiary per month. Total spending under this provision would be \$11.8 million. This includes \$1.4 million for aged, \$1.5 million for disabled, \$1.6 million for parents and \$7.3 million for children.

e. Medicaid Adult Dental Coverage

Under the Commission proposal, the Combined Medicaid and CHP+ programs would be extended to cover dental care for adults. Under the current program, dental care is not covered for adults unless it is surgery. It does not cover routine check-ups, cleanings, shots, fillings and

³ “Rate Development for the Colorado Family Care Program :Fiscal Year 2008,” (report to the Department of Health Care Policy and Financing), Leif Associates, inc., December 2005.

⁴ A discussion of the general methodology used is presented in: “Comparing Physician and Dentist Fees Among Medicaid Programs,” (report to the Medi-Cal Policy Institute), the Lewin Group, June 2001.

⁵ Personal communication with Dr. Steve Poole, executive director, Colorado Children’s Health Care Access Program based on the cost experience of providing similar services to pediatric clients under the CCHAP program.

other dental services. Based upon spending data provided by the Colorado Medicaid program, we estimate that total spending for the limited amount of dental care that the program does cover will be about \$6.3 million in 2007/2008. This includes parents, the disabled and the aged.

We estimated the cost of expanding coverage to include the full range of dental services up to \$1,000 annually for all adults in the Medicaid program using the MEPS data in HBSM. We identified adults in these data who have dental coverage and estimate surgical costs and other dental health services separately. We then took the ratio of total dental costs to surgical costs for this population. This showed that the dental spending for surgery is equal to about 35 percent of total dental spending for commercially insured adults. Alternatively stated, total dental spending was equal to about 285 percent of surgical spending. Using this figure, we estimate that expanding dental benefits for adults (including aged, disabled and parents) to include the expanded list of dental services would add about \$11.7 million to program costs.

f. Medically Correctible Program

The Commission proposes to establish a program that would provide non-medical assistance to ill or disabled people in cases where a one-time expenditure would enable the individual to work or live independently. The Commission proposes funding of \$5.0 million per year.

We estimated the savings to Medicaid based upon an analysis of the cost and benefits of a similar program in Colorado that was eliminated in 2002. These data indicate that each dollar of spending under the program resulted in savings of \$0.44 per recipient beneficiary per year. These data also indicate that long-term savings are equal to about \$2.47 for every dollar spent, assuming it enables people to stay off of the program until they reach age 60. Using these data we estimated that the proposed \$5.0 million in spending under the medically correctible program would result in savings of about \$2.2 million in the first year of the program. The added savings in subsequent years is included in the 10-year cost projections presented below.

3. Enrollment in Premium Subsidy Program

The premium subsidies would reduce the cost of insurance to eligible people, resulting in an increase in the number of people taking coverage. We estimated the impact of the premium subsidy on the number of people purchasing non-group coverage by treating the subsidy as a change in the price of insurance to the individual. This reduction in price would result in an increase in the likelihood that such a family would voluntarily purchase coverage.

We simulated the impact of this reduction in price by using a multivariate model of how the likelihood of purchasing coverage changes as the price of coverage (i.e., the premium) is reduced. This model shows an average price elasticity for coverage of -0.34 (i.e., a 1.0 percent decrease in premiums is associated with an increase in coverage of about 0.34 percent). However, the impact of changes in premiums on coverage varies with the income and demographic characteristics of affected people. For example, the price elasticity varies from about -0.31 among people with family incomes of \$50,000 to -0.55 among those with incomes of \$10,000. Thus, the price response tends to be higher for low-income people than for high-income people.

We used these price elasticity assumptions to simulate the change in coverage for uninsured people in the MEPS-based HBSM data. The model was used to estimate the premium faced by each uninsured individual and family in the individual market compared to the premium in the private pool, and the amount of the subsidy that eligible people would receive. Affected individuals were then randomly selected to become covered based upon the change in the net cost of insurance to the individual (i.e., premium less the premium assistance received) and the price elasticity assumptions discussed above. This step involved the following assumptions:

- We used the premiums for the CHP+ benefits package;
- All HBSM simulations were performed on a month-by-month basis to account for people who are eligible for only part of the year; and
- All income-eligible people who are currently purchasing non-group coverage are assumed to take the premium subsidy if eligible.

4. Mandate Compliance

The proposal includes a mandate for all Colorado residents to have health insurance. We first simulate voluntary enrollment for people newly eligible for subsidized coverage as described above. We then assume full compliance among people where the cost of insurance would not exceed 9.0 percent of their income.⁶ Others would remain uninsured.

5. Employer Response to Premium Subsidies

The availability of subsidies for non-group coverage reduces the relative advantages of taking coverage through tax preferred ESI, which could cause some employers to discontinue their coverage, although this is substantially reduced by the 6-month waiting period. Also, the expansion in eligibility for Medicaid and CHP+ would encourage some of the lower-wage workers away from ESI and into public programs. However, the requirement that all people have insurance would increase worker demand for group coverage, which could cause some employers to begin offering coverage.

We simulated employer coverage decisions based upon whichever approach allows the employer's workforce to purchase coverage at the lowest cost. We did this by first calculating the cost of covering their workers and dependents under ESI, less any premium subsidies their workers are eligible to receive and the taxes saved due to the tax exclusion for employer provided health benefits. We then calculate the cost to the group of enrolling their workers in: Medicaid/CHP+ where eligible, the public assistance plan where eligible and unsubsidized individual coverage for people with incomes above 400 percent of the FPL.

We assume that employers will do whichever minimizes the cost of coverage to the group. Thus, those that find that the cost of providing ESI is greater than the cost of acquiring non-ESI

⁶ Our estimate of affordability is based on a review of a recent article by Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," in *Health Affairs* [Health Affairs 26, no. 3 (2007): 770-779].

coverage do not offer coverage. Those who find it is less costly for the group to obtain coverage through ESI are assumed to purchase ESI. The methods used to simulate the employer's decision are presented in *Appendix H*.

6. Program Administration

We assumed that the cost of administering eligibility for the Medicaid CHP+ expansion would be about \$170 per family per year. This is based on detailed data on the cost of administering eligibility under the Medicaid program. We assume that the insurer's cost of administering coverage under each of these benefit packages was equal to 19 percent of covered claims. This assumption is based on experience in large health plans operating in the non-group market. This estimate is lower than the rate in the existing market of about 35 percent and assumes economies of scale under the proposal that would reduce administrative costs.

7. Wage Effects

We assume that employer costs for health benefits are passed on to workers in the form of changes in wages. Thus, increases in employer costs are assumed to be passed on to workers in the form of reduced wages while decreases in health benefits expenses are passed back to employees in the form of reduced wage growth. This assumption is based upon the economic principle that the total value of employee compensation, which includes wages, employer payroll taxes, health benefits and other benefits, is determined in the labor markets.

There is considerable agreement among economists that this wage pass-through would occur in response to changes in employer benefit costs.⁷ However, there is disagreement over the period of time over which these adjustments would occur. It is likely that these adjustments would often take the form of reduced wage growth over time. However, the full amount of the pass-through could take several years to materialize. For illustrative purposes, we present our estimates assuming the pass-through is complete in the first year.⁸

8. Administrative Simplification

The Commission proposal includes several steps that would reduce administrative costs for health care providers. These include provisions designed to streamline and standardizing processes used to confirm coverage, submit claims and credential providers. These include:

- Require all health plans to issue ID cards that conform to ANSI and WEDI standards and require all ID cards to use magnetic strips that conform to WEDI standards;
- Standardize provider credentialing procedures;
- Simplify eligibility and coverage verification processes;

⁷ See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" *American Economic Review*, (May 1993).

⁸ See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in *Tax Policy and the Economy* (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* (May 1989).

- Standardize and streamline claim form attachments;
- Standardize prior authorization procedures, including those of Medicaid; and
- Create standardized and simplified appeals process for all carriers

a. Hospital Administration

Figure 8 presents our estimates of hospital expenses for services and administration in Colorado for 2007/2008. We calculated hospital revenue and expenses using the Colorado Medicare Hospital Cost report data for 2004, which include data on hospital administrative costs by functional area. Because some hospitals reported the data in more detail than others, it was necessary to develop a method for allocating costs to detailed administrative functions based upon the allocation of costs reported by Colorado hospitals with full reporting. We then aged these data to 2007/2008 in proportion to the projected rate of growth in hospital spending in Colorado over the 2004 through 2007/2008 period. The data and methods used to develop these estimates are presented in *Appendix B* and are the same as that used in our analysis of the single-payer proposal discussed above.

We estimated savings in each functional area as shown in *Figure 8*. Separating administrative costs into sub-functions enables us to distinguish those areas likely to be affected by the Commission's proposal from those functions that would not be affected. For example, we expect savings in credit and collections due to universal coverage, but do not expect it to have an impact on other costs such as laundry and food service. For each of these sub-functional areas, we estimated the percent savings that would be achieved for each affected area based upon interviews with industry experts.

Using this approach, we estimate that the cost of administration for hospitals would be reduced by about \$48.6 billion if fully implemented in 2007/2008.

Figure 8
Estimated Hospital Administrative Savings Under Commission Proposal

	Hospital Care Expense	Expense Attributed to Patient Care	Value Allocated to Administration	Assumed Percent Savings	Savings Under Program
Total Adjusted Hospital Operating Revenue	\$10,426.0	\$7,139.7	3,286.3	1.5%	\$48.6
Daily Hospital and Ancillary Services Cost	\$5,119.6	\$5,119.6	0.0	0.0%	\$0.0
Research Costs	\$1,37.4	\$0.0	137.4	0.0%	\$0.0
Education Costs	\$92.9	\$0.0	92.9	0.0%	\$0.0
General Costa	\$665.4	\$474.6	190.8	7.2%	\$13.7
Non-Patient Food Services	\$3.8	\$0.0	\$3.8	3.6%	\$6.9
Maintenance and Repairs	\$85.2	\$75.1	\$10.2	5.0%	\$0.5
Plant Operations & Maintenance	\$194.7	\$169.2	\$25.4	5.0%	\$1.3
Data Processing	\$101.8	\$0.0	\$101.8	5.0%	\$5.1
Other General Services	\$279.9	\$230.3	\$49.6	0.0%	\$0.0
Fiscal Services	\$433.8	\$0.0	\$433.8	4.1%	\$17.6

	Hospital Care Expense	Expense Attributed to Patient Care	Value Allocated to Administration	Assumed Percent Savings	Savings Under Program
Patient Accounting	\$273.5	\$0.0	\$273.5	5.0%	\$13.7
Credit & Collection	\$17.8	\$0.0	\$17.8	5.0%	\$0.9
Admitting	\$30.5	\$0.0	\$30.5	10.0%	\$3.1
Other Fiscal Services	\$112.0	\$0.0	\$112.0	0.0%	\$0.0
Administrative Services	\$706.1	\$0.0	\$706.1	2.4%	\$16.7
Hospital Administration	\$334.6	\$0.0	\$334.6	5.0%	\$16.7
Other Administrative Services	\$371.5	\$0.0	\$371.5	0.0%	\$0.0
Unassigned Costs	\$960.6	\$0.0	\$960.6	0.1%	\$0.5
Depreciation and Amortization	\$376.6	\$323.9	\$52.7	1.0%	\$0.5
Other Unassigned Costs	\$134.9	\$0.0	\$584.0	0.0%	\$0.0
Total Operating Expenses	\$8,115.9	\$0.0	\$2,521.7	0.0%	\$0.0
Net Operating Revenue	\$2,310.1	\$0.0	\$764.6	0.0%	\$0.0

Source: Lewin Group Estimates.

b. Physician Administration

We estimated the distribution of physician administrative costs for Colorado based upon expense report data from the 2006 Medical Group Management Association (MGMA) cost survey (based on 2005 data) of physician practices (*Figure 9*). Because state-level data are not available from the survey, we used data for the west region of the country for the Colorado study. The survey includes responses from 335 physician practices nationwide. We used the distribution of operating costs for non-hospital or IDS (Integrated Direct Service) multi-specialty practices. To generate this distribution of costs by function, we allocated our estimates of total physician income in Colorado for 2007/2008 in proportion to the distribution of costs in the MGMA data for the Western region of the country. The data and methods used to develop these estimates are presented in *Appendix B*.

We then developed assumptions on how much could be saved from simplified administration for each individual administrative function. For example, we anticipate that standardizing rules and coverage verifications procedures would reduce costs associated with patient accounting and claims adjudication, but would have little impact on such things as housekeeping and security. Our assumed percentage savings by functional category is based upon interviews with industry experts at the Lewin Group and elsewhere in the industry.

The proposal would also standardize the process used to credential physicians. Currently, each physician may need to be credentialed for up to 17 health plans according standards that differ across individual health plans. Evidence from case studies of savings where standardized credentialing has been adopted indicates that credentialing costs could be reduced by about 11 percent.

Based upon this analysis, we estimate that physician administrative costs would be reduced by about \$117 million if these administrative provisions were adopted in 2007/2008 (*Figure 9*).

Figure 9
Estimated Physician Administrative Savings under the Commission Proposal

	Total Revenues by Expenses	Direct Patient Care Expenses	Expenses Attributed to Administration	Assumed Percent Reduction in Administration	Estimated Savings under Program
Non-Physician Salaries & Benefits	\$2,831.6	\$1,007.8	\$1,823.8	4.4%	\$81.1
General administrative	\$213.2	\$0.0	\$213.2	5.0%	\$10.7
Medical credentials	\$13.7	\$0.0	\$13.7	11.0%	\$1.5
Patient accounting	\$211.9	\$0.0	\$211.9	5.0%	\$10.6
General accounting	\$47.6	\$0.0	\$47.6	5.0%	\$2.4
Managed care administrative	\$60.1	\$0.0	\$60.1	5.0%	\$3.0
Information technology	\$74.3	\$0.0	\$74.3	2.0%	\$1.5
Medical receptionists	\$298.7	\$0.0	\$298.7	5.0%	\$14.9
Med secretaries, transcribers	\$69.2	\$0.0	\$69.2	5.0%	\$3.5
Registered nurses	\$219.4	\$197.5	\$21.9	10.0%	\$2.2
Licensed practical nurses	\$101.8	\$89.6	\$12.2	10.0%	\$1.2
Med assistants, nurse aides	\$318.7	\$283.6	\$35.1	5.0%	\$1.8
Total employee support staff benefits	\$457.2	\$0.0	\$457.2	5.0%	\$22.9
Tot contracted supp staff	\$101.8	\$0.0	\$101.8	5.0%	\$5.1
Other	\$643.2	\$437.1	\$206.1	0.0%	\$0.0
Total General Operating Cost	\$2,467.9	\$1,466.6	\$1,001.3	1.1%	\$10.9
Information technology	\$150.2	\$0.0	\$150.2	5.0%	\$7.5
Building and occupancy	\$545.6	\$409.2	\$136.4	1.0%	\$1.4
Furniture and equipment	\$99.3	\$76.4	\$22.9	1.0%	\$0.2
Admin supplies and services	\$164.4	\$0.0	\$164.4	1.0%	\$1.6
Miscellaneous operating costs	\$176.0	\$0.0	\$176.0	0.1%	\$0.2
Other	\$1,333.2	\$981.0	\$352.2	0.0%	\$0.0
Total Operating & Non-Phys. Exp.	\$5,299.5	\$2,474.4	\$2,825.1	3.3%	\$92.1
Physician Expense	\$3,043.5	\$2,800.0	\$243.5	10.3%	\$25.1
General administration	\$99.2	\$0.0	\$99.2	5.0%	\$5.0
Pre-Service utilization mgmt.	\$14.6	\$0.0	\$14.6	20.0%	\$2.9
Claims denial and adjudication	\$86.0	\$0.0	\$86.0	20.0%	\$17.2
Other	\$2,956.6	\$2,877.1	\$79.4	0.0%	\$0.0
Total Net Patient Revenues	\$8,343.0	\$5,274.4	\$3,068.6	3.8%	\$117.1

Source: Lewin Group estimates.

C. Cost and Coverage Impacts

In this section we present our estimates of the cost and coverage impacts of the Commission's proposal. For purposes of this section, we assumed that the Commission's recommendations

are implemented without the Optional Continuous Coverage Portable plan alternative or the 24-hour Coverage proposal described above in recommendations 14 and 15. We discuss the potential impact of including these additional recommendations in the sections that follow.

1. Transitions in Coverage

The Commission's proposal requires all residents of the state of Colorado to have health insurance. The program would expand eligibility under the Medicaid program and would provide subsidies for the purchase of private health insurance. People are exempt from the mandate to have coverage if the cost of insurance to the individual exceeds nine percent of income.

The proposal combines Medicaid and CHP+ into a single program for all eligible populations except the aged, disabled and foster children. It expands the program to cover children through 250 percent of the FPL and parents of eligible children below 205 percent of the FPL. In addition, the program covers childless adults and legal non-citizens through 205 percent of the FPL. It creates a subsidized buy-in to Medicaid coverage for the disabled living below 450 percent of the FPL and creates a medically needy program for people with high health expenditures relative to their income. The proposal creates mechanisms to improve outreach, enrollment and access to services.

The Commission's proposal would also provide subsidies for the purchase of private health insurance for people living below 400 percent of the FPL. The premium subsidies would apply to the purchase of a CHP+ benefits package for those with incomes below 300 percent of the poverty level. The subsidy for people between 300 percent and 400 percent of the FPL would be for the minimum benefits package described above. The proposal also makes changes in the private insurance markets designed to make affordable coverage available to all state residents, expands eligibility for the high-risk pool (i.e., CoverColorado), and creates a clearinghouse from which individuals can obtain information about health insurance options and become covered. These programs apply to all citizens and legal residents of the state. The undocumented are not eligible for subsidies under Medicaid or the premium assistance program and are not mandated to have health insurance.

As discussed above, we estimate that by 2007/2008, the number of uninsured in Colorado would increase to 791,800 people. The proposal covers all but 97,500 of these uninsured people, which is almost 88 percent of Colorado's uninsured population. Of these uninsured people, 420,000 would become covered under the Medicaid/CHP+ program. Another 208,900 would be covered through private non-group coverage, which includes 10,400 people covered under CoverColorado, and 91,600 people who would receive premium subsidies for private non-group coverage. Also, about 106,900 uninsured people who would not qualify for subsidies (i.e., incomes in excess of 400 percent of the FPL) would obtain coverage in the non-group market.

In addition, 65,400 uninsured people would take employer sponsored coverage of which about 19,700 people would receive a subsidy for the employee share of the premium. This subsidy is provided only to those who have been uninsured for six-months or more prior to taking employer coverage.

Figure 10 illustrates changes in sources of coverage for those who currently have coverage. We estimate that of the 2.7 million people currently receiving ESI, 51,500 people would move into the expanded Medicaid/CHP+ program. In addition 105,800 people would move into private non-group coverage. These include workers who are eligible for a subsidy who may opt to purchase more comprehensive coverage than is offered by their employer, either in the private market or through CoverColorado.

Figure 10
Transitions in Coverage under the Commission's Proposal in 2007/2008 (1,000s)

Base Case Coverage		Employer Sponsored Insurance (ESI)		Private Non-ESI Coverage			Public Coverage				Not Insured
		Employer- No Subsidy <i>a/</i>	Employer - With Subsidy	Non- Group - Subsidy	Non- Group - Non- Subsidy	Cover Colorado	TRICARE	Medicare Excl. Dual Eligible	Medicare Dual Eligible	Medicaid And CHP+	
Employer	2,691.7	2,534.4	0.0	53.0	47.9	4.9	0.0	0.0	0.0	51.5	0.0
Non-Group	158.9	47.8	0.0	51.1	38.5	8.8	0.0	0.0	0.0	12.7	0.0
TRICARE	112.4	0.0	0.0	0.0	0.0	0.0	112.4	0.0	0.0	0.0	0.0
Medicare (excl. dual eligibles)	413.0	0.0	0.0	0.0	0.0	0.0	0.0	375.4	37.6	0.0	0.0
Medicare Dual Eligible	50.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	50.0	0.0	0.0
Medicaid/ CHP+ (excl. dual eligible)	402.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	402.1	0.0
Uninsured	791.8	45.7	19.7	91.6	106.9	10.4	0.0	0.0	0.0	420.0	97.5
Total	4,619.9	2,627.9	19.7	195.7	193.3	24.1	112.4	375.4	87.6	886.3	97.5

a/ Includes people who use their subsidy for ESI coverage.

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

Figure 11 shows the change in the number of uninsured under the proposal by age and income, assuming the program is fully phased in by 2007/2008. The proposal covers a significant proportion of lower-income people because of the subsidies provided to low-income individuals, as well as the expansion in Medicaid/CHP+ eligibility. The proposal also covers a significant proportion of higher income people because it provides subsidies for people up to 400 percent of the federal poverty level (FPL).

The proposal would cover about 88.5 percent of uninsured people with incomes below \$50,000 compared to 86 percent of the uninsured with incomes of \$50,000 or more. With the premium subsidies provided and the public expansions for parents and non-custodial adults, the program covers 87 percent of people between the ages of 19 and 34.

Figure 11
Change in Uninsured under the Commission's Proposal in 2007/2008 (thousands)

	Uninsured Under Current Law (1,000s)	Newly Covered Under Program (1,000s)	Number Remaining Uninsured (1,000s)
Family Income			
Under \$10,000	90.1	80.7	9.4
\$10,000-\$19,999	108.9	96.3	12.6
\$20,000-\$29,999	127.0	111.4	15.5
\$30,000-\$39,999	118.3	108.3	10.0
\$40,000-\$49,999	79.3	66.8	12.5
\$50,000-\$74,999	122.9	108.0	14.9
\$75,000-\$99,999	66.5	56.1	10.4
\$100,000-\$149,999	48.5	41.7	6.8
\$150,000 & over	30.4	25.0	5.4
Age			
Under 6	58.8	52.8	6.0
6-18	98.7	91.9	6.8
19-24	123.3	107.2	16.1
25-34	192.4	167.9	24.5
35-44	146.6	126.1	20.5
45-54	112.1	96.4	15.7
55-64	58.5	51.3	7.2
65 and over	1.4	0.9	0.5
Total	791.8	694.3	97.5

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

2. Impact on Statewide Health Spending

As discussed above, we estimate that health spending for Colorado residents will be about \$30.1 billion in 2007/2008. This includes spending for all health services by all payers including Medicare, Medicaid, ESI, non-group insurance, workers compensation and various safety-net programs. Spending includes payments for services, and the cost of administering both public and private health insurance coverage.

Health spending in Colorado would increase by about \$987 million in 2007/2008 under the proposal (*Figure 12*). This is an increase in statewide health spending of about 3.3 percent. This reflects several impacts that the program would have on spending including increased utilization for the newly insured, changes in provider reimbursement and the administrative cost of administering subsidies and expanded coverage.

Figure 12
Changes in Statewide Health Spending under the Commission Proposal in 2007/2008 (millions)

Current Statewide Health Spending for All Payers		\$30,100
Change in Health Services Expenditures		\$916
Change in utilization for newly insured	\$739	
Change in utilization for currently insured	\$72	
Medicaid case management and wraparound benefits ^{a/}	\$15	
New services covered under HCBS waivers	\$90	
Reimbursement Effects		\$137
Net payments for previously uncompensated care	\$240	
Increase Medicaid payment rates ^{b/}	\$70	
Reduced payment levels for privately Insured moving to Medicaid	(\$81)	
Reduced Cost Shifting	(\$92)	
Change in Administrative Cost of Programs and Insurance		(\$66)
Change in insurer administration	\$77	
Administration of subsidies ^{c/}	\$23	
Physician administrative costs ^{d/}	(\$117)	
Hospital administrative costs ^{d/}	(\$49)	
Total Change in Statewide Health Spending		\$987

a/ Includes increased utilization for case management and Medically correctible services.

b/ Includes increased cost of conversion from Medicaid to CHP+ and increased physician payment rates for aged and disabled.

c/ Assumes premium subsidies will be administered at a cost of \$171 per family for determining eligibility.

d/ Savings resulting from standardization of forms, plan rules and credentialing requirements.

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

a. Health Services Utilization

We assume that utilization of health services would increase for newly insured people to the levels reported by insured people with similar demographic and health status characteristics. Utilization would also increase slightly for those individuals previously covered in less comprehensive health plans. This approach shows a net increase in utilization, as people use their subsidies for private coverage to move into more comprehensive health coverage, and as people access new services such as case management, waiver services and other wrap around services.

Using these assumptions, we estimate an increase in health services utilization of \$916 million, of which \$739 million is attributed to increased utilization for newly insured people and \$72 million for people who obtain improved coverage. In addition, \$15 million is attributable to case management services, services provided under the new Medically Correctible program and Medicaid wrap around services. Another \$90 million is attributable to the increases in people getting home and community-based waiver services.

b. Reimbursement Effects

Under the proposal, total payments to providers for previously uncompensated care would be \$240 million in 2007/2008. Under the current system, uncompensated care from services to the uninsured and underinsured is shifted to private payers in the form of higher charges in a process known as cost-shifting. Based upon the literature on cost shifting, we assume that about 40 percent of the change in provider payment rates would be passed on to private payers in the form of lower negotiated payment rates, thereby reducing cost shifting by about \$92 million.

The proposal also increases provider payment from Medicaid rates to CHP+ rates for parents, children and childless adults, and increases Medicaid provider payment rates for aged and disabled people. We estimate that the increase in Medicaid payment levels increases spending by \$70 million. Under the proposal 51,500 people move from employer coverage to Medicaid/CHP+ and 12,700 move from private non-group coverage to Medicaid/CHP+. The result of this coverage transition is a reduction in payment levels for services provided to these people from private rates to Medicaid/CHP+ rates. We estimate that this change in payment levels as people move from private coverage to public coverage would save \$81 million, although some of these costs would be shifted to private payers through the cost-shift.

c. Administration

The proposal includes several administrative simplification provisions designed to reduce the cost of administration for providers. These include standardizing coverage verification, claims processing, appeals processes and credentialing procedures.

The cost of administration in the health care sector would decrease by about \$66 million. Insurer administration for newly insured people would increase by \$77 million and the cost of administering subsidies under the proposal would be \$23 million. These increases would be more than offset by the savings achieved through the administrative simplification provisions in the proposal. These simplifications would result in savings in physician administration of \$117 million and savings in hospital administration of \$49 million.

3. Program Spending

Figure 13 shows the costs under the proposal for the public program expansions, improvements and eligibility simplification assuming they are fully implemented in 2007/2008. We estimate the total costs to be \$2.0 billion, including both state and federal dollars. With the exception of the Medicaid look-alike program for legal non-residents, we assumed the federal government would share in the cost of the program under an approved 1115 waiver.

Figure 13
Enrollment and Costs of Medicaid/CHP+ Expansions under the Commission Proposal in 2007/2008

	Eligible (1,000s)	Enrollment (1,000s)	Reduction in Uninsured (1,000s)	Total Costs (millions)	State Costs (millions)	Federal Costs (millions)
Changes in Benefits and the Delivery System						
Physician Rate Increase for Aged/Disabled	0.0	0.0	0.0	\$6.6	\$3.3	\$3.3
Targeted Case Management	0.0	0.0	0.0	\$11.8	\$5.9	\$5.9
Benefits Improvements for CHP+ Children	0.0	0.0	0.0	\$7.8	\$3.9	\$3.9
Managed Care for Medicaid Families	0.0	0.0	0.0	\$63.3	\$31.7	\$31.7
Adult Dental Service	0.0	0.0	0.0	\$11.7	\$5.9	\$5.8
Medically Correctible Net Cost	0.0	0.0	0.0	\$2.8	\$3.9	(\$1.1)
Benefits	0.0	0.0	0.0	\$5.0	\$5.0	\$0.0
Savings	0.0	0.0	0.0	\$2.2	\$1.1	\$1.1
Subtotal	0.0	0.0	0.0	\$104.1	\$54.6	\$49.5
Auto-enrollment for Uninsured Currently Eligible not Enrolled, with 12 month Certification and Eligibility Simplification						
Medicaid Children	26.8	26.8	26.8	\$41.8	\$20.9	\$20.9
SCHIP Children	29.7	29.7	29.7	\$48.8	\$18.7	\$30.1
Adults	11.0	11.0	11.0	\$30.6	\$15.3	\$15.3
Subtotal	67.5	67.5	67.5	\$121.2	\$54.9	\$66.3
Medicaid/CHP+ Expansions						
Parents - 205% of FPL	193.2	142.8	128.6	\$485.3	\$242.7	\$242.6
Childless adults - 205% FPL	279.5	204.7	168.4	\$732.7	\$366.3	\$366.4
Children - 250% of the FPL	37.6	20.9	13.9	\$40.8	\$14.3	\$26.5
Subtotal	510.3	368.4	310.9	\$1,258.8	\$623.3	\$635.5
Medicaid Look-Alike for Legal Non-Residents to 205% FPL						
Children	16.0	11.6	9.9	\$22.1	\$22.1	\$0.0
Parents	14.6	13.2	11.2	\$44.7	\$44.7	\$0.0
Childless adults	20.7	19.3	17.5	\$69.1	\$69.1	\$0.0
Subtotal	51.3	44.1	38.6	\$135.9	\$135.9	\$0.0
Home and Community-Based Waivers						
Children's HCBS waivers	0.5	0.5	0.0	\$14.5	\$7.2	\$7.3
Child Autism Waiver	0.7	0.7	0.0	\$17.2	\$8.6	\$8.6
Developmental Disability (DD) HCBS	8.2	8.2	0.0	\$147.9	\$87.3	\$60.6
Subtotal	9.4	9.4	0.0	\$179.6	\$103.1	\$76.51
Expansions for Aged/Disabled						
Disabled to 200% FPL	9.3	4.2	0.0	\$38.7	\$19.4	\$19.4
Aged to 200% FPL b/	74.3	33.4	0.0	\$55.3	\$27.7	\$27.7
Buy-in for Disabled d/	12.2	7.8	1.9	\$35.4	\$17.7	\$17.7
Full-cost Buy-in - Disabled over 450% FPL	0.5	0.5	0.0	\$0.0	\$0.0	\$0.0
Subtotal	97.4	47.0	1.9	\$134.4	\$67.2	\$67.2
Medically Needy Program to 50% FPL						
Families	8.2	8.2	0.0	\$7.5	\$3.8	\$3.8
Childless adults	22.6	22.6	0.0	\$28.9	\$14.5	\$14.5
Subtotal	30.8	30.8	0.0	\$36.4	\$18.2	\$18.2
Total Program ^{a/}	757.3	557.8	420.0	\$1,970.4	\$1,057.2	\$913.2

a/ There would be an additional cash flow adjustment of \$67.1 million as people move to pre-paid plans.
Source: The Lewin Group estimates using the Health Benefits Simulation Model

d. Changes to the Medicaid and CHP+ Programs

The proposal merges children covered under CHP+ into a single program with Medicaid eligible children, parents, pregnant women and childless adults. All of these people would be

covered through a delivery system similar to the existing CHP+ delivery system. This means that the Medicaid population would be covered largely under private health plans in Managed FFS. However, the payment rates for these health plans imply roughly a 10 percent increase in costs for those now covered under Medicaid, which would cost about \$63.3 million.

Also, the proposal would cover all of these enrollees for the services now covered under Medicaid except nursing home facilities and HCBS programs. This would improve coverage for the current CHP+ population by: making them eligible for EPSDT services; reducing co-payments for services; and removing limits on services under the existing CHP+ program. This would increase costs by \$7.8 million. In addition, the program would expand dental benefits for adults at a cost of \$11.7 million. The increase in physician payments to 75 percent of Medicare payment levels would cost an additional \$6.6 million. The combined cost of these increases in covered services and provider payments would be \$104.1 million. Automatic enrollment and 12-month certification would cost \$121.2 million and would cover 67,500 uninsured people.

The proposal expands Medicaid/CHP+ for parents and childless adults to 205% FPL, which would cost \$1.2 billion. It also expands CHP+ for children to 250 percent of the FPL which we estimate would cost an additional \$40.8 million. The proposal creates a Medicaid look-a-like, state-funded program for legal non-residents up to 205 percent of FPL. This program would be wholly state-funded and we estimate it would cost about \$135.9 million.

The Department has estimated that the expansion in home and community-based waivers for children and developmentally disabled people would cost \$179.6 million. The proposal also expands Medicaid to aged and disabled people up to 205 percent of FPL and creates a buy-in program for disabled people which results in a total cost of \$134.4 million. This includes a cost of \$94.0 million for the expansions for the aged and disabled people and \$35.4 million for the buy-in for people with disabilities and with income up to 450 percent of FPL. These costs exclude the expansion for the full-cost buy-in for disabled people with income above 450 percent of FPL as they are paying the full cost of the program. In addition the proposal creates a Medically Needy program for people up to 50 percent of FPL. We estimate that the cost of this program would be \$36.4 million.

As discussed above, the Commission proposes to improve access to providers for Medicaid participants by enrolling people in integrated delivery systems and managed care. This means moving from a system where claims are paid in the months following the date of service to a system where the full amount of the capitation payment to the plans occurs at the beginning of each month. Consequently, the program would experience a one-time increase in the flow of funds that would add about \$67.1 million to program payments in the first year of the program only.

e. *Premium Subsidy Program*

The proposal provides subsidies for the purchase of private health insurance for families and childless adults who are not eligible for the expanded Medicaid/CHP+ program that are living below 400 percent of the FPL. People up to 250 percent FPL receive a full subsidy and those between 251 percent and 300 percent of the FPL receive an 80 percent subsidy. In addition, the plan provides a subsidy for people between 300 percent and 400 percent of the FPL who would face premiums for the minimum benefit plan that exceed 9 percent of their income. We assume that a federal 1115 waiver would be granted so the state would receive federal matching funds for subsidies provided to families and childless adults. *Figure 14* shows premium subsidy costs for people below 400 percent of FPL under the proposal assuming it is fully implemented in 2007/2008.

Figure 14
Premium Subsidy Costs for Private Insurance for People Below 400% FPL under the Commission's Proposal in 2007/2008

	Number Who Use Subsidy (1,000s)	Subsidy Costs - Families (millions)	Subsidy Costs - Childless Adults (millions)	Subsidy Costs - Total (millions)	State Costs (millions) ^{a/}	Federal Costs (millions)
Premium Subsidy for People living below 300% of FPL						
Subsidies for ESI Premiums ^{b/}	19.7	\$22.7	\$20.4	\$43.1	\$21.6	\$21.5
Subsidies for Non-Group Premiums ^{b/}	190.8	\$243.6	\$251.0	\$494.6	\$247.3	\$247.3
Total	210.5	\$266.3	\$271.4	\$537.7	\$268.9	\$268.8
Subsidize Premium Over 9% of Income for People Between 300% and 400% of FPL						
Subsidies for ESI Premiums	0.0	--	--	--	--	--
Subsidies for Non-Group Premiums	11.1	\$7.7	\$8.3	\$16.0	\$8.0	\$8.0
Total	11.1	\$7.7	\$8.3	\$16.0	\$8.0	\$8.0
Total Premium Subsidy Program						
Total	221.6	\$274.0	\$279.7	\$553.7	\$276.9	\$276.8

a/ Assumes Federal waiver to receive matching funds for subsidies to families and childless adults.

b/ Assumes a 100% premium subsidy for people below 250 percent of the FPL and an 80 percent subsidy for people between 250 and 300% FPL.

Source: The Lewin Group estimates using the Health Benefits Simulation Model.

To qualify for the program, the coverage purchased by the family or individual must be equivalent to the current CHP+ benefits package for people living below 300 percent of the FPL, or the minimum benefits plan for those between 300 percent and 400 percent of the FPL. To target the subsidy to people currently without insurance, the program includes a waiting period requirement that limits eligibility to only those who have been without insurance for 6 or more months prior to enrollment. The premium subsidy can be used to pay the worker share of the premium for ESI only if the family or individual meets the 6 month waiting period.

We estimate the total cost of the subsidy for people below 300 percent of FPL would be \$537.7 million. Of this, about \$43.1 million is attributable to an estimated 19,700 people who use their subsidies to pay their share of ESI. Another \$494.6 million is attributable to an estimated 190,800 people who obtain private non-group coverage with the subsidy. We estimate that there would be 11,100 people between 300-400 percent of FPL who would face premiums that exceed 9 percent of their income. We estimate the subsidy costs for this group to be \$16 million.

f. New public spending for People by Current Insured Status

Figure 15 shows the distribution of people receiving subsidized coverage under the proposal by current insured status. These programs would provide \$2.5 billion in benefits to about 778,900 people. Of these, about 537,400 people would be newly insured with benefits of about \$1.7 billion. There would be about 241,500 currently insured people who would receive subsidies of about \$809.8 million. Thus, about 69 percent of new spending under the program would go to people who otherwise would have been uninsured.

Figure 15
Distribution of Subsidies by Current Insuring Status under the Commission's Proposal in 2007/2008 ^{a/}

	Number Receiving Subsidies (1,000s)	Total Amount of Subsidies (millions) ^{b/}	State Share (millions) ^{c/}	Federal Share (millions)
Medicaid Expansion				
Currently Insured	137.3	\$519.8	\$281.6	\$238.2
Currently Uninsured	420.0	\$1,450.6	\$775.6	\$675.0
Total	562.3	\$1,970.4	\$1,057.2	\$913.2
Premium Subsidies				
Currently Insured	104.2	\$270.2	\$135.1	\$135.1
Currently Uninsured	117.4	\$283.5	\$141.8	\$141.7
Total	221.6	\$553.7	\$276.9	\$276.8
All Subsidies				
Currently Insured	241.5	\$790.0	\$416.7	\$373.3
Currently Uninsured	537.4	\$1,734.3	\$917.4	\$816.7
Total	778.9	\$2,524.3	\$1,344.1	\$1,190.0

a/ Includes premium subsidies and public program costs under the Medicaid expansions. We assume a Federal Medicaid waiver is obtained to receive matching funds for childless adults and other expansions.

b/ Includes costs for newly enrolled, delivery system changes and expanded benefits for currently eligible people.

c/ Includes people newly enrolled in Medicaid including those where Medicaid coverage is provided as a supplemental benefit (e.g., elderly expansion).

Source: The Lewin Group estimates using the Health Benefits Simulation Model.

About 137,300 of those who would be newly covered under Medicaid would be people who are already insured under current law. This includes about 64,200 low-income people who move from private employer or non-group coverage to the program due to expansions in eligibility. It also includes about 37,600 Medicare recipients who would become eligible for Medicaid supplemental coverage due to the expansions in eligibility for the aged and disabled to 205 percent of the FPL. An additional 35,500 people would become covered through the new medically needy program (i.e., people with high health care costs not covered by insurance) and the new HCBS waiver benefits that would have coverage from some other source.

4. Individual Market Coverage for Coloradans over 300 percent of FPL

As discussed above, all Colorado residents are required to have health insurance. People living above 300 percent of the FPL are required to have coverage that is at least as comprehensive as the minimum benefit plan described above. Some of the uninsured in this income group are actually eligible for coverage offered by their employer but have declined to enroll. We anticipate that nearly all of these people would respond to the mandate by enrolling in their employer's plan. Other uninsured living above 300 percent of the FPL would obtain non-group coverage through either the non-group market or CoverColorado, the state's high-risk pool.

In addition, those between 300 percent and 400 percent of the FPL would also be eligible for a subsidy that would reduce their cost of the minimum benefits plan to no more than 9 percent of their income. The subsidy could be used to purchase employer, individual or CoverColorado coverage, depending on the coverage they are eligible for. *Figure 16* provides estimates of enrollment and spending for CoverColorado under the proposal.

Figure 16
CoverColorado Coverage, Revenues and Expenses under the Commission Proposal in 2007/2008

CoverColorado Enrollment and Costs	Enrollees (1,000s)	Beg. Fund Balance + Interest (millions)	Premium Payments (millions)	Property Fund Revenue & Grants (millions)	Total Revenue (millions)	Claims and Admin. Costs (millions)	Ending Balance (millions)
Current Program	7.0	\$34.8	\$28.7	\$27.0	\$90.5	\$67.2	\$23.3
Coverage and Costs Under the Proposal ^{a/}							
Current Enrollees	6.3	\$34.8	\$17.2 ^{b/}	\$27.0	\$79.0	\$60.5	\$18.5
New Enrollees	17.8	--	\$48.6 ^{b/}	--	\$48.6	\$127.6	(\$79.0)
Total	24.1	\$34.8	\$65.8 ^{b/}	\$27.0	\$127.6	\$188.1	(\$60.5)

a/ CoverColorado would be available only to people in the individual market with income in excess of 300 percent of the FPL.

b/ Premium payments would be assessed at 100 percent of the indexed rate instead of 150 percent as under current law.

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The proposal would reform the CoverColorado program. An expanded list of chronic conditions would be used to identify people eligible for the program. All of those seeking coverage in the non-group market who have one of these high-cost health conditions would be

covered under the high-risk pool. People above 300 percent of FPL who are not eligible for CoverColorado would be able to obtain non-group coverage on a guaranteed issue basis (i.e., the insurer would not be permitted to decline to cover someone due to health status). Rating for the non-group products for people not eligible for CoverColorado would be at a modified community rate. Modified community rating means that premiums may vary with age, geography and dependent status (e.g., single, family, etc.) but may not be varied with health status. We estimate that there would be about 190,200 people who are not eligible for CoverColorado and would therefore obtain coverage in the non-group market.

The CoverColorado program itself would be modified in three ways under the proposal. First, the list of chronic conditions that qualify people for the high-risk pool would be expanded from its current list, with the goal of enrolling the 10 percent most costly of insurance applicants under CoverColorado. Second, insurers would not be permitted to decline individuals for minor conditions not included in the list. Third, CoverColorado enrollees would pay a premium equal to 100 percent of a standard risk premium, which is an actuarial estimate of the average cost of the CoverColorado benefits package to someone of that age across the entire population (i.e., not just the chronically ill). This would be a one-third reduction in the premium charged in the program, which is currently equal to about 150 percent of standard risk. Premiums would only vary by age, geography and family type only.

There are currently 7,000 people covered through CoverColorado. We estimate that total enrollment under the proposal would be 24,100 which includes 6,300 people currently enrolled and 17,800 new enrollees. CoverColorado is financed in part through assessments on insurers, state funds, interest on unclaimed property and premiums. Premium payments would increase from \$28.7 million under current law to \$65.8 million under the proposal. Total revenue from the property fund and beginning balance in the fund, including interest, would go to fund the program. The total revenue under the program would increase from \$90.5 million to \$127.6 million as a result of the increased premium payments.

However, program and claims administration costs would grow from \$67.2 million to \$188.1 million under the proposal as enrollment increases. We estimate that the program would operate at a \$60.5 million deficit under the proposal, assuming the state is prepared to draw-down the existing surplus in CoverColorado funding. If the state decides not to draw down these reserves, the program would cost the state about \$95.3 million, assuming the program is implemented in 2007/2008.

5. Impact on State and Local Government Budgets

We estimate that new program costs to the state under the proposal would be \$1.5 billion, assuming an 1115 waiver is approved by the federal government to receive federal matching funds for the program expansions. For illustrative purposes, we assumed the proposal is fully phased-in with the Medicaid/CHP+ program expansions in 2007/2008 (*Figure 17*). New state costs under the program with the waiver would be about \$1.1 billion for the expansion of Medicaid and CHP+, \$276.9 million in premium subsidies for people up to 400 percent of FPL, \$95.3 million for the CoverColorado expansion, and \$23 million for public health and nursing services. The cost for administering the subsidies would be \$11.5 million.

Figure 17
Change in State and Local Government Spending Under the Commission's Proposal in
2007/2008 (millions)

	Change in Spending with Waiver		Change in Spending without Waiver	
New Program Costs		\$1,464.1		\$2,306.9
Medicaid/CHP+ Expansion	\$1,057.4		\$1,621.4	
Premium Subsidies a/	\$276.9		\$553.7	
Administration of Subsidies	\$11.5		\$23.0	
Cover Colorado b/	\$95.3		\$95.3	
Funding for Local Public Health and Nursing Services	\$23.0		23.0	
New Revenues and Offsets to Existing Programs		\$1,464.1		\$2,306.4
Savings to Current Safety Net Programs c/	\$218.8		\$164.8	
State & Local Government Employee Health Benefits	--		--	
Workers and Dependent Benefits (\$46.5)				
Wage Effects d/ \$46.5				
Sales Tax Revenues	\$377.2		\$377.2	
Tobacco Tax increase \$210.0				
Alcohol Tax Increase \$126.2				
Nutrition Sales Tax Net of Administrative Cost (1%)\$41.0				
State Personal Income Tax Rate Increase e/	\$854.4		\$1,753.4	
Tax Revenue Gain Due to Wage Effects f/	\$13.7		\$13.7	
Net Cost/(Savings) to State and Local Government		\$0.0		\$0.0

a/ Premium subsidy amounts include subsidies for people below 300 percent of the FPL and for those between 300 percent and 400 percent of the FPL.

b/ The proposed CoverColorado expansion would operate at a deficit and require state funding. We assumed that beginning of year balances would be maintained as reserves and are not used to offset operating costs in the year.

c/ Includes care currently paid for by other safety net programs. Assumes waiver is approved to allow state to continue to receive Federal DSH funding to be used for the program.

d/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.

e/ Assumes that the personal income tax rate (currently 4.63 percent) would be increased to the level required to fully fund the program. We estimate an increase of 0.7 percentage points if the waiver is granted and 1.7 percentage points if the waiver is not granted.

f/ Increase in tax revenue is counted as an offset to State and Local Government health spending.

Source: The Lewin Group estimates using the Health Benefits Simulation Model.

These new costs would be offset by savings in other programs and new tax revenues. Program costs for safety-net providers such as clinics and other state and local programs would be reduced as the number of uninsured declines under the proposal. This is because providers would now be reimbursed for health services that were formerly provided free to uninsured people who become covered under the proposal. State and local governments would save about \$218.8 million in safety-net program spending in this way (*Figure 17*), assuming the state is granted a federal waiver to retain the \$54 million in federal disproportionate share hospital (DSH) payments to help fund the coverage expansions.

We also estimate that there would be a reduction in state costs for state employee health benefits, which we assume to be passed on to workers in the form of higher wages in a process called the “wage effect”. We estimate that the increase in wages would generate additional tax revenue of \$13.7 million.

New tax revenues from the tobacco and alcohol tax increase proposed under the program would be \$336.2 million. There would also be new tax revenues of \$41 million from a newly established nutrition sales tax on all food and drinks determined to have little or no nutritional value. Additional revenue would be required to fully fund the program, which would be generated through an increase in the personal income tax rate. We estimate that the personal income tax rate (currently at 4.63 percent) would need to be increased by 0.8 percentage points to fully fund the program. We estimate that this would generate revenues of about \$854.4 million.

6. Change in Federal Government Health Spending

The net change in federal government spending, less offsets, would be \$1.5 billion, assuming an 1115 waiver is approved (*Figure 18*). Of these new program costs, \$967.2 million are attributed to new Medicaid/CHP+ enrollment under the expansion. The federal portion of the premium subsidies for people up to 400 percent of the FPL would be \$276.8 million. This assumes the proposal is fully phased-in with expansions in 2007/2008.

Figure 18
Change in Federal Government Spending under the Commission Proposal in 2007/2008 (millions)

	Change in Spending With Waiver	Change in Spending Without Waiver
Federal Program Costs		
Medicaid/CHP+ Expansion	\$967.2	\$302.3
Premium Subsidies ^{a/}	\$276.8	\$0.0
Administration of Premium Subsidies	\$11.5	\$0.0
Mandated Section 125 Plans	\$372.9	\$372.9
Total Federal Costs	\$1,628.4	\$675.2
Federal Program Revenues and Offsets		
Federal Employee Health Benefits	\$0	\$0
Workers and Dependent		
Wage Effects ^{b/}		
Tax Revenue Due to Wage Effects ^{c/}	\$113.2	\$113.2
Total Federal Program Revenues and Offsets	\$113.2	\$113.2
Net Cost/(Savings) to Federal Government	\$1,515.2	\$562.0

a/ Includes premium subsidies to both those living below 300 percent of the FPL and subsidies for people living between 300 percent and 400 percent of the FPL.

b/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.

c/ Reduction in tax revenue is counted as an increase in Federal Government health spending.

Source: The Lewin Group estimates using the Health Benefits Simulation Model.

These estimates reflect the requirement under the Commission's proposal that employers set up "premium-only" plans under Section 125 of the US tax code. These plans would allow workers to pay their premiums for non-group coverage in pre-tax withholding, thus partially offsetting the cost of this coverage by reduced tax payments. Employers would establish these plans even if they do not contribute to the cost of the worker's coverage. The net loss of revenue to the federal government would be \$372.9 million, which we estimate based upon the marginal tax rates for people at their reported income levels.

We assume that savings to employers resulting from reduced cost-shifting and the discontinuation of a small number of employer health plans would be passed back to workers as an increase in wages over time resulting in new tax revenues of \$113.2 million. Similarly, there also would be savings (\$16.8 million) in federal worker health benefits that we also assume would be passed back to workers as higher wage increases over time.

7. Impact on Private Employers

Figure 19 presents our estimates of the impact of the proposal on private employers if fully implemented in 2007/2008. There is no employer mandate under the proposal, so there is no change in spending for non-insuring firms. Currently insuring private employers currently spend about \$8.1 billion on health benefits for workers and dependents, and retirees. We estimate that these employers would see savings of about \$334 million under the proposal, largely though the elimination of a small number of employer health plans.

Although overall employer spending would decrease, there would be shifts in coverage and other effects that could have a substantial impact on spending for certain employers. We estimate that private employers would spend about \$55 million more in health benefits as a result of the individual mandate, as workers and dependents who previously did not take coverage do so under the plan to comply with the mandate.

Reductions in employer spending would result from some employers who would drop coverage in response to the mandate. This would include primarily employers that would have started offering coverage in the year that would not do so due to the availability of subsidized coverage for their workers in the non-group market under the proposal. This loss of employer coverage would reduce private employer spending by about \$345 million. We also estimate that private employers would save \$44 million due to reduced cost-shifting for uncompensated and under-compensated care (See discussion above). Thus, private employers in Colorado would save about \$337 million overall under the proposal in 2007/2008, primarily from savings incurred by employers who drop coverage due to new subsidies available to low-income workers.

These savings do not reflect increases in wages as employers pass on savings from lower health care costs to their workers in the form of increased wages. Employers overall save \$2 million after taking into account the wage effect. These estimates include employer spending for all covered workers, dependents and retirees living in Colorado, even if the employer is based outside the state. This excludes federal workers and state and local government employees, which were discussed above. This estimate also includes only the employer share of the costs of coverage. Changes in the worker's share of premiums for ESI are presented in the next section.

Figure 19
Changes in Private Employer Health Benefits Costs under the Commission's
Proposal in 2007/2008 (millions)

	Currently Insuring Employers	Currently Non-Insuring Employers ^{a/}	All Employers
Private Employer Spending Under Current Law			
Current			
Workers & Dependents	\$7,720	--	\$7,720
Retirees	\$350	--	\$350
Total	\$8,070	--	\$8,070
Change in Private Employer Spending Under the Policy			
Employees Who Previously Declined Coverage	\$55	--	\$55
Employers Dropping Coverage	(\$345)	--	(\$345)
Reduced Cost Shifting	(\$44)		(\$44)
Net Change (before wage effects)	(\$334)	--	(\$334)
Net Change in Spending After Wage Effects			
Net Change (after wage effects)	(\$2)	--	(\$2)

a/ We estimate that 62,400 workers and dependents will be covered by firms not currently offering coverage that will decide to offer coverage due to the individual mandate. However, we assume these employers will not contribute to the cost of the premium.

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

8. Impact on Family Health Spending

Under the Commission's proposal, family health spending would decline by about \$245.3 million under the program. Family premium payments would increase by about \$412.4 million, reflecting the increase in the number of people taking health insurance. This increase in premium payments would be more than offset by \$553.7 million in premium subsidies provided under the proposal and \$95.3 million in CoverColorado premium subsidies (i.e., costs in excess of premium revenues). Out-of-pocket spending (including co-pays and deductibles) for families would decrease by \$606.8 million due to expanded coverage (*Figure 20*).⁹ Families would save about \$372.9 million as employers are required to set up Section 125 premium-only plans, thus allowing families to pay their share of benefit costs in pre-tax dollars, resulting in a tax savings.

As discussed above, we assume that as employers spend less on health care benefits, they would pass these savings on to workers in the form of increased wages. The increases in after tax wages are counted here as savings in family health spending of \$270.4 million. The proposal would be partly funded by tobacco and alcohol tax increases of \$336.2 million and a sales tax on foods and beverages with no nutrition value of \$41 million. In addition families would spend

⁹ We assume that half of the spending for services that would become covered under the HCBS waivers would replace payments for those services now paid by families out-of-pocket.

\$854.2 million more due to the increase in the personal income tax rate. Overall, families would save about \$255.1 million on health care under the proposal, taking into account the wage effect.

Figure 20
Impact of the Commission Proposal on Family Health Spending in
2007/2008 (in millions)

	Change in Spending Before Wage Effects	Change in Spending After Wage Effects
Change in Premiums	(\$236.6)	(\$236.6)
Change in Family Premiums \$412.4		
Premium Subsidies (\$553.7)		
Cover Colorado Subsidies (\$95.3)		
Change in Out-of-Pocket Payments	(\$606.8)	(\$606.8)
Acute and Primary Care (\$516.9)		
Services covered under HCBS waivers (\$89.9)		
Section 125 Plans	(\$372.9)	(\$372.9)
After Tax Wage Effects ^{a/}	--	(\$270.4)
Sales Tax Revenues	\$377.2	\$377.2
Tobacco Tax increase \$210.0		
Alcohol Tax Increase \$126.2		
Nutrition Sales Tax Net of Administrative Cost (1%) \$41.0		
Increase State Personal Income Tax Rate (0.7% w/ waiver)	\$854.4	\$854.4
Net Change	\$15.3	(\$255.1)

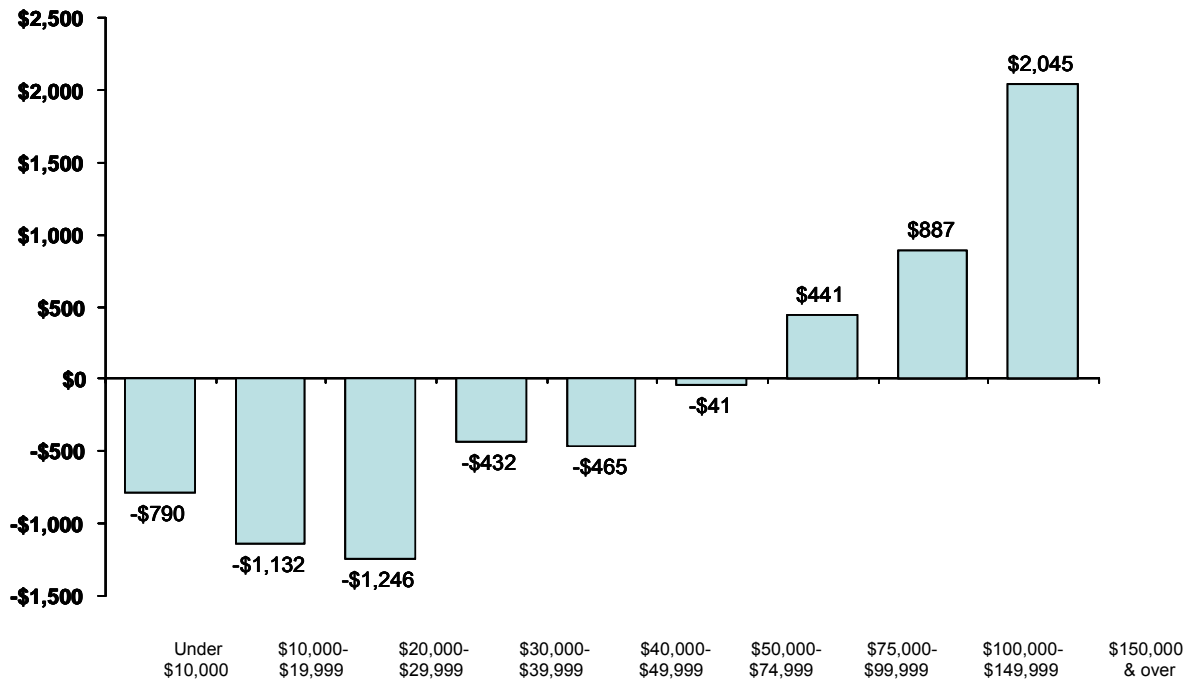
a/ The increase in after-tax wage income resulting from reduced costs to employers are counted here as a reduction in family health spending.

b/ Assumes that the personal income tax rate is increased to fully fund the program, assuming the state receives the 1115 waiver.

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The decrease in health spending is more dramatic for lower-income families because of the premium subsidies (*Figure 21*). Families with income between \$10,000 and \$20,000 would save an average of about \$1,132 in 2007/2008. Those with incomes between \$20,000 and \$30,000 would save on average about \$1,246 per family. Spending would on average increase by about \$2,045 per year for families with incomes of \$150,000 or more.

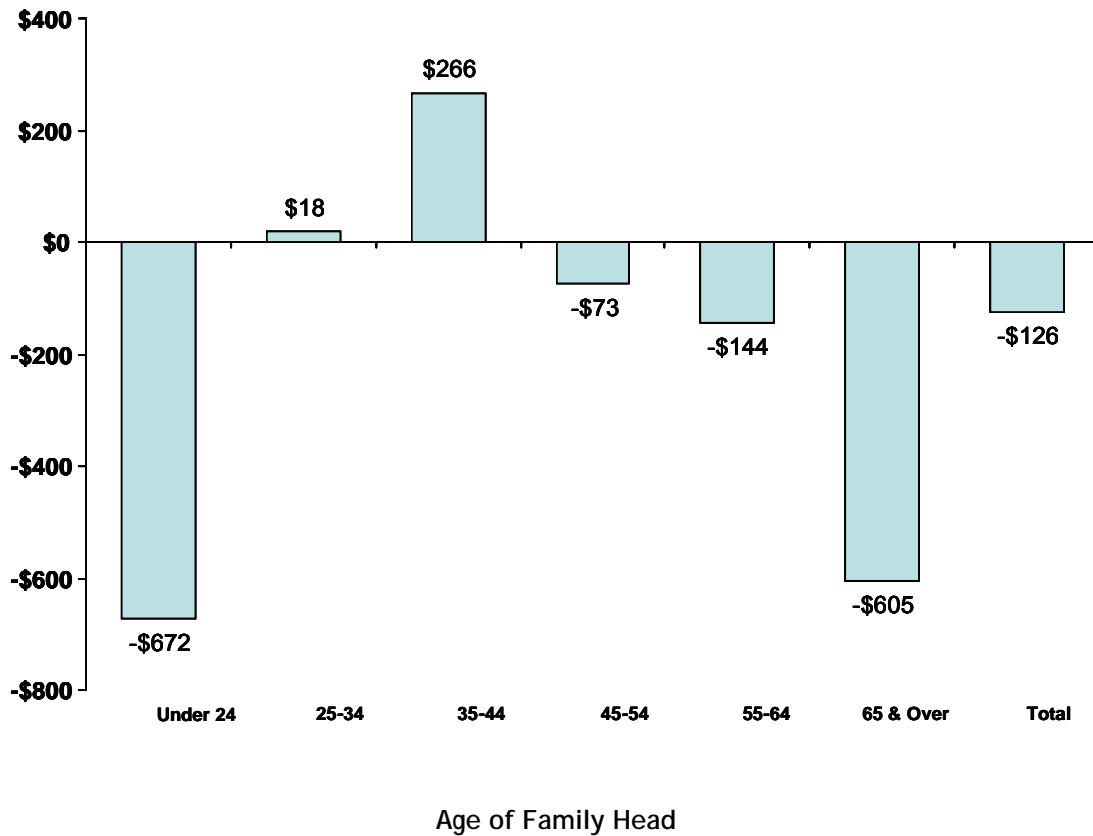
Figure 21
Change in Average Family Health Spending by Income Group under the
Commission's Proposal in 2007/2008



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

On average, families would see savings averaging about \$126 in 2007/2008 under the proposal (*Figure 22*). People in a family headed by someone age 24 or younger would save about \$672 per family. This reflects the availability of subsidies for low-income uninsured adults, many of whom are in younger age groups.

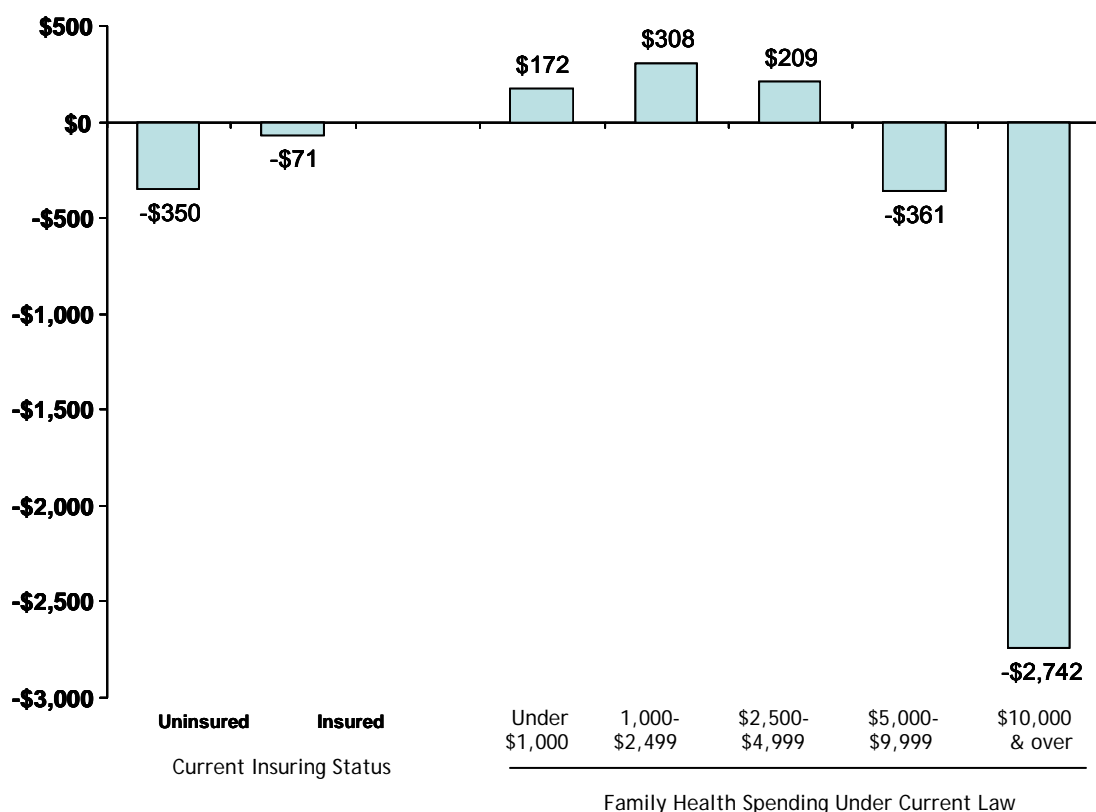
Figure 22
Change in Average Family Health Spending by Age of Family Head under
the Commission's Proposal in 2007/2008



Source: The Lewin Group estimates using the Health Benefits Simulation model (HBSM)

As illustrated in *Figure 23*, currently uninsured families would on average save about \$350, largely due to the subsidies provided under the program. Those who are currently insured would save only \$71 more on average, reflecting the increase in the number of people who have insurance. Those families currently spending \$10,000 or more on health care would see average savings of about \$2,742 per family.

Figure 23
Change in Average Family Health Spending by Current Law Insurance Status and Family Health Spending under the Commission's Proposal in 2007/2008



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

Figure 24 shows the distribution of families in Colorado by the amount by which the program would change health spending for individual families. This reflects changes in premiums, out-of-pocket spending, subsidies, taxes used to fund the program and after tax wage changes under the proposal. About 69.1 percent of Colorado families would see a net reduction in health spending of \$20 or more. About 11.7 percent of families would see a net increase in spending of \$20 or more. Only about 19.1 percent of the population would be unaffected (i.e., changes of less than \$20).

Figure 24
Distribution of Families by the Amount of the Change in Total Family Health Spending
Under the Commission's Proposal

	PERCENT DISTRIBUTION OF FAMILIES											
	ALL FAMILIES TOTAL	INCREASE IN FAMILY HEALTH COSTS					NO CHANGE +/- \$20	REDUCTION IN FAMILY HEALTH COSTS				
		\$1,000 +	\$500-\$999	\$250-\$499	\$100-\$249	\$20-\$99		\$20-\$99	\$100-\$249	\$250-\$499	\$500-\$499	\$1,000 +
Family Income												
< \$10,000	176607.9	0.4	0.4	0.1	0.0	1.4	49.6	7.5	9.0	6.7	6.3	18.6
\$10K-\$19,999	225278.6	0.5	0.0	0.2	0.3	0.3	37.3	13.5	5.9	5.5	8.1	28.3
\$20K-\$29,999	229048.7	1.5	0.0	0.4	1.8	0.1	25.9	19.4	7.4	6.8	12.6	24.0
\$30K-\$39,999	237519.9	6.6	3.4	2.8	1.8	2.3	19.7	20.3	8.8	5.9	7.1	21.3
\$40K-\$49,999	200288.9	5.1	1.7	2.1	2.9	0.7	19.7	26.5	4.9	5.5	11.0	20.0
\$50K-\$74,999	316232.1	10.5	3.1	2.3	1.6	1.2	9.8	31.1	8.1	6.2	8.3	17.6
\$75K-\$99,999	238563.4	9.9	2.6	1.1	1.1	0.7	6.8	34.9	12.0	6.5	8.5	15.9
\$100K-\$149,9	190449.2	9.9	2.2	1.0	1.8	0.4	6.4	35.2	12.9	6.9	11.3	11.9
\$150,000 +	177815.6	9.5	2.5	1.9	1.2	0.6	1.9	36.3	13.4	4.6	11.3	16.9
Income as a Percent of the FPL												
Below Poverty	225931.2	0.4	0.3	0.2	0.0	1.1	48.3	7.5	8.8	7.3	7.6	18.5
100%-199%	333666.2	0.8	0.2	0.2	0.4	0.3	27.8	16.1	7.8	6.3	7.3	32.7
200%-299%	319529.9	2.6	0.7	2.0	2.9	1.6	20.5	20.7	7.4	5.8	14.0	21.9
300%-399%	284848.4	13.8	3.6	2.2	2.8	1.6	11.7	25.3	9.1	5.4	8.2	16.2
400%-499%	221889.0	9.6	3.1	2.2	1.3	0.6	16.1	30.3	7.0	6.6	7.1	16.1
500% +	605939.7	8.5	2.6	1.5	1.1	0.6	7.2	37.3	11.3	5.8	9.9	14.1
Age of Family Head												
18 - 24	211676.5	3.5	1.9	1.3	1.1	1.2	22.0	24.7	7.4	8.6	7.9	20.4
25 - 34	417966.1	6.7	3.1	2.1	3.0	1.8	15.4	28.7	9.4	5.2	8.5	16.1
35 - 44	425342.2	9.5	2.0	1.3	1.4	0.9	9.4	30.3	10.4	6.2	10.8	17.7
45 - 54	413248.7	8.0	1.7	1.5	0.6	0.6	10.0	28.6	12.8	8.3	8.6	19.4
55 - 64	257395.7	4.0	1.3	1.4	1.6	0.5	18.7	26.7	8.9	5.5	9.8	21.6
65 +	266175.3	1.8	0.4	0.4	0.2	0.0	52.5	5.3	1.8	2.2	10.0	25.3
Out-of-pocket Spending under Current Law												
Below \$1,000	455047.8	7.6	3.3	1.6	0.7	1.3	39.6	20.8	8.6	7.0	5.1	4.6
\$1,000-\$2,499	431768.0	6.5	1.8	1.6	3.3	1.2	17.5	30.7	5.1	9.0	8.6	14.7
\$2,500-\$4,999	529014.4	7.0	1.5	0.8	0.6	0.7	12.4	33.0	8.6	5.4	12.7	17.3
\$5,000-\$9,999	422893.2	4.0	1.3	1.7	1.5	0.6	10.8	21.2	12.6	3.7	11.7	30.8
Above \$10,000	153081.0	5.1	0.2	1.4	1.0	0.3	8.4	7.3	12.9	4.1	5.7	53.6
Family Members with Health Insurance												
1+ Uninsured	385868.6	14.3	3.7	1.4	1.3	0.4	23.2	8.3	8.4	9.3	8.6	21.1
No Uninsured	1605935.9	4.3	1.4	1.4	1.5	1.0	18.1	29.3	9.2	5.3	9.5	19.1
All Families												
Total	1991804.4	6.2	1.8	1.4	1.4	0.9	19.1	25.2	9.0	6.1	9.3	19.5

Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM)

D. Ten-Year Cost Projections

The estimates presented up to this point assume that the program is fully phased-in and implemented in 2007/2008. We did this to illustrate the potential impact of the fully operational program on the health care system and key stakeholder groups in current year dollars.

Of course, the program could not be implemented that quickly, since we are already in the 2007/2008 year. In addition, experience with prior program expansions indicates that there are likely to be substantial enrollment lags in the early years of the program. It will take time for people to become aware of their potential eligibility and then find the time to enroll, even with the mandate to have coverage. Thus, not all of the 687,000 uninsured people we expect to become covered under this proposal would enroll immediately.

Based upon analyses of enrollment under prior program expansions, we typically assume that the program reaches only 40 percent of the ultimate enrollment level in the first year, 80 percent in the second year and 100 percent every year thereafter. However, we assume that enrollment would occur more rapidly under the program due to the mandate to have insurance. We assume that enrollment would reach 75 percent of its ultimate enrollment level in the first year of the program, 90 percent in the second year and 100 percent there-after.

Total net new spending under the program would be \$45.2 billion over the 2008/2009 to 2017/2018 period (*Figure 25*). About \$12.8 billion of this would be covered through federal matching funds. These are the estimates that should be used for budgeting purposes because they reflect likely enrollment behavior in the early years of the program.

Figure 25
New State Program Costs under the Commission's Proposal 2008/2009 through 2017/2018 ^{a/}
(millions)

	Total Spending (millions)	State Spending	Federal Spending
2008/2009	\$2,181.8	\$1,174.6	\$1,007.2
2009/2010	\$2,809.6	\$1,512.6	\$1,297.1
2010/2011	\$3,337.6	\$1,796.8	\$1,540.8
2011/2012	\$3,564.5	\$1,918.9	\$1,645.5
2012/2013	\$3,814.1	\$2,053.3	\$1,760.8
2013/2014	\$4,081.1	\$2,197.1	\$1,884.0
2014/2015	\$4,362.7	\$2,348.7	\$2,014.0
2015/2016	\$4,659.3	\$2,508.3	\$2,151.0
2016/2017	\$4,976.2	\$2,678.9	\$2,297.2
2017/2018	\$5,314.5	\$2,861.1	\$2,453.4
Total 2008/2017	\$39,101.2	\$21,050.2	\$18,051.0

a/ Estimates assume lags in enrollment for newly eligible people in the first two years of the program.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

E. 24-Hour Coverage

During the course of this study, we estimated the impact of permitting employers to combine their workers compensation health benefits with their health and long-term disability coverage. Under current law, employers must purchase a Workers Compensation policy to cover workers for work-related injuries. The policy provides medical services related to work injuries and cash compensation for those who are no longer able to work due to these injuries. The medical benefit typically includes the cost of rehabilitative services.

As discussed in *Appendix B*, we estimate that health benefits under workers compensation in Colorado will be \$714 million. This includes \$448 million in payments for health services and \$230 billion in administrative costs. Thus administrative costs are equal to about 51 percent of benefits payments. These administrative costs are high relative to the cost of administering employer sponsored coverage, which currently averages about 14 percent of covered benefits in Colorado.

The reason for the higher cost of administration for Workers Compensation benefits is the cost of adjudicating claims. To receive benefits under Workers Compensation, the worker must prove that their injury of disability is actually work-related. Often these claims are contested by the insurer resulting in legal expenses for both the carrier and the individual.

Under the 24-hour coverage proposal, employers would be permitted to fold their workers compensation coverage into their health and disability insurance plans. Under this model, the health plan covers the worker for all health services regardless of whether they are attributed to work-related injuries. Similarly, the disability policies would cover workers for ongoing medical costs incurred by disabled workers regardless of the source of their disability. Cash benefits would also be determined through the disability policy, thus eliminating adjudication costs attributed to cash workers compensation benefits. Administrative costs are reduced under this model because there is no longer any need to go through the expensive process adjudicating whether each injury is work-related.

This approach eliminates the adjudication process for determining whether the disability is work related. We anticipate that this would reduce the cost of administering coverage for those medical services that would have been covered under workers compensation.

The 24-hour coverage option would be most relevant to employers who offer both health and disability benefits. We estimate that 64 percent of all workers compensation medical benefits are attributed to people who have employer coverage (*Figure 26*). This is true under both current law and the Commission's recommended coverage expansions.

Figure 26
Distribution of Worker's Compensation Medical Benefits by Workers Primary Source of Coverage

Primary Source of Coverage	People (1,000s)	Workers Comp Medical Benefits & Admin. (\$1,000s)	Distribution of Spending
Current Law			
Employer - Worker	1,427	\$459,835	64%
Employer - Dependent	1,265	\$45,700	7%
Non Group	159	\$4,695	1%
CHAMPUS	112	\$46,011	6%
Medicare (excl. dual eligible)	413	\$72,037	10%
Medicaid/CHP+ (incl. dual eligible)	452	\$1,121	0%
Uninsured	792	\$84,601	12%
Total	4,620	\$714,000	100%
Under the Policy			
CoverColorado	24	\$411	0%
Non-Group with Subsidy	196	\$8,485	1%
Non-Group without Subsidy	1933	\$38,382	5%
Employer - Worker	1,403	\$457,809	64%
Employer - Dependent	1,245	\$45,278	7%
CHAMPUS	112	\$46,011	6%
Medicare (excl. dual eligible)	375	\$72,037	10%
Medicaid/CHP+ (incl. dual eligible)	974	\$44,186	6%
Uninsured	105	\$1,401	0%
Total	4,620	\$714,000	100%

Source: The Lewin Group estimates using the Health Benefits Simulation model (HBSM).

We assume that the administrative costs under 24-hour coverage for services provided due to workplace injury would be roughly the same as the cost of administering other employer health insurance benefits. Using this assumption, we estimate that if all workers with health coverage were to participate in 24-hour coverage plans, employers would save about \$101 million per year (*Figure 27*). There would also be other savings that we have not been able to quantify including:

- Legal costs for beneficiaries applying for Workers Compensation benefits;
- Employer cost of maintaining multiple policies;
- Delays in processing eligibility for benefits; and
- Lost worker productivity.

Figure 27
Permit Employers to Combine Workers Compensation with Employer Health Insurance

	Amount
Current Spending	
Worker's Comp Health Benefits	\$484.0 million
Worker's Comp Administration and Adjudication	\$230.0 million
Total	\$714.0 million
Combine Workers Comp and Health Benefits	
Covered Workers in Firms with Health Benefits	1.4 million
Amount of Workers Comp. for Workers in Insuring Firms (includes Medical benefits and administration)	\$459.8 million
Potential Administrative Savings ^{a/}	\$101.0 million

a/ Assumes that administrative costs as a percentage of benefits for workers compensation medical benefits would be that same as under employer health benefits plans (14 percent rather than the 51 percent administrative share for the current workers compensation program).

Source: The Lewin Group estimates using the Health Benefits Simulation model (HBSM).

There are ways in which this 24-hour coverage could increase costs. For example, simplifying the process for covering work-related injuries could result in claims for people who have injuries but who not have pursued a claim due to the need to engage an attorney to navigate the adjudication process. Also, the health benefits offered by the employer would need to be expanded to include the therapy benefits required to treat disabilities, which could result in added costs for the employer.

Another issue with this approach is that it could fragment the insurance pool for those who would remain in traditional workers compensation programs. As an optional program, it is possible that there will be some systematic bias in the employers electing this approach which could result in higher premiums for those who continue with the existing workers compensation model. These issues should receive careful study before adopting the 24-hour coverage model.

F. Impacts of the Optional Continuous Coverage Portable Plan

The Commission considered an additional coverage option called the Optional Continuous Coverage Portable Plan (OCCPP), which could be implemented together with the other coverage expansions called for in the Commission's recommendation. Under this option, Colorado residents would have the option of enrolling in a single state-operated program that is similar to the single-payer program called the Colorado Health Services Program (CHSP), which we also discuss elsewhere in this study. For modeling purposes, we assume that the benefits package would be the CHP+ benefits package discussed above.

People who elect to enroll in the program would agree to enroll in the program for 10 years. Enrollees would pay an annual fee to the program, which would equal 8.1 percent of family income. (As discussed above, the CHSP would be funded with an increase in the state's income

tax rate of 8.1 percentage points.) In addition, all funding for any subsidized coverage that these individuals would have had under the Commission's proposal would be transferred to the OCCPP to help fund the program. In addition, employers are permitted to transfer to the OCCPP whatever they would have paid to cover these individuals under their employer health plan.

1. Transitions in Coverage

We estimated the number of people enrolling in the program assuming that people will enroll in the program if it is less costly. We first estimated coverage and costs under the Commission's proposal including the Medicaid expansions and the premium subsidy program described above. We then compared the premium payments that people would be required to pay if they enroll in the OCCPP with what they would pay for the coverage they would have under the Commission's proposal. Individuals were selected to enroll in the OCCPP program only if it is less costly to them, subject to the following constraints:

- Not all of those who would pay less are assumed to enroll. We estimated the number enrolling based upon studies of the likelihood of changing coverage given the availability of alternative coverage at a lower cost;
- The likelihood of shifting to the OCCPP is in proportion to the amounts saved by doing so; and
- We assumed that people enrolled in Medicaid/CHP+, where there are no premiums, would shift to the OCCPP, only in cases where they would have paid premiums for private coverage sometime during the year when not eligible for the program.

Using these criteria, we estimate that about 493,000 people would take coverage under the OCCPP once established (*Figure 28*). The people enrolling in the OCCPP would tend to include lower-income people where the increase in the income tax (i.e., 8.1 percentage points) is less than what they would pay to have private coverage. Conversely, higher-income people would tend to find that the increase in the income tax is greater than the premium they would pay for their current private health insurance.

Figure 28
Transitions in Coverage with the Optional Continuous Coverage Portable Plan in 2007/2008
(thousands)

Coverage Under the Proposal without the Optional Continuous Coverage Portable Plan		No Change in Coverage	Optional Continuous Coverage Portable Plan
Employer*	2,648	2,317	331
Non-Group - With Subsidy	196	257	16
Non-Group - Without Subsidy	193	56	61
Cover Colorado	24	12	12
CHAMPUS	112	112	0.0
Medicare (excl. Dual Eligible)	375	375	0.0
Medicaid/CHP+ (incl. Dual Eligible)	974	907	67
Uninsured	97	99	6
Total	4,620	4,127	493

* Includes people who use their subsidy for ESI coverage.

Source: The Lewin Group estimates using the Health Benefits Simulation Model.

2. OCCPP Revenues and Costs

The cost of benefits under the OCCPP for the 493,000 people enrolling in the program would be \$2.8 billion, including benefits and administration (**Figure 29**). Revenues would be \$2.1 billion leaving a funding deficit of about \$753 million. Revenues include funding all of the public subsidies that these people receive under the Commission proposal including Medicaid, the premium subsidy program and savings to public safety-net programs. It also includes about \$1.1 billion that employers would have spent on health insurance coverage for those who decide to enroll in the OCCPP.

There would be a substantial funding shortfall (i.e., \$753 million) reflecting the use of the income tax increase as the premium amount that participants are required to pay. People with low incomes would tend to pay less under the income tax increase than they would pay in premiums under the Commission's recommended program discussed above. Thus, the income tax-based premium payments typically would be less than what is required to fully fund the program.

A key assumption in this analysis is that the employer would voluntarily contribute the amounts that they would have paid for the coverage they would have provided to workers that decide to enroll in the OCCPP. This feature must be voluntary because ERISA prohibits the states from requiring employers to provide coverage. Because the employer contribution has no affect on the premium paid by workers enrolling in OCCPP, many employers may decide not to make these payments. If no employers make these payments, the funding shortfall under the program would increase from \$753 million to \$1.8 billion.

Figure 29
Optional Continuous Coverage Portable Plan Coverage and Costs in 2007/2008 - Assuming no Enrollment Controls

	Assumes Employers Pay Into The Program ^{a/}		Assumes Employers Do Not Contribute ^{b/}	
	Premium = 8.1% Income Tax	Premium = \$225 Per Person Per Month ^{c/}	Premium = 8.1% Income Tax	Premium = \$225 Per Person Per Month ^{c/}
Enrollment (1,000s)	493.5	190.2	493.5	190.2
Program Costs (millions)				
Benefit Costs	\$2,804.2	\$1,202.8	\$2,804.2	\$1,202.8
Administration	\$34.1	\$13.1	\$34.1	\$13.1
Total Costs	\$2,838.3	\$1,215.9	\$2,838.3	\$1,215.9
Revenues and Offsets (millions)				
Premium	\$576.2	\$513.8	\$576.2	\$513.8
<i>Employer Contribution</i>	<i>\$1,086.7</i>	<i>\$622.9</i>	<i>\$0.0</i>	<i>\$0.0</i>
Medicaid/CHP+	\$354.0	\$11.3	\$354.0	\$11.3
Other Safety Net Programs	\$17.1	\$7.1	\$17.1	\$7.1
Premium Subsidies	\$51.2	\$6.9	\$51.2	\$6.1
Total	\$2,085.2	\$1,162.0	\$998.5	\$539.1
Net Program Costs/(Savings) in millions				
Net Program Costs	\$753.1	\$53.9	\$1,839.8	\$676.8

a/ Assumes employers pay into the program what they currently contribute to employee premiums.

b/ Assumes some employers drop coverage and do not contribute to the program.

c/ Assumes a premium equal to half of the cost of coverage in the program.

Source: The Lewin Group estimates using the Health Benefits Simulation model (HBSM)

3. Impact of an Alternative Premium

Enrollment and costs under the OCCPP are very sensitive to the methods used to determine the premium that enrollees are required to pay. To illustrate, we estimated the program's impacts assuming that instead of the 8.1 percent income, enrollees would be required to pay a premium equal to half of the average monthly cost per enrollee under the program, which is about \$225 PMPM. Using this premium, we estimate that about 190,000 people would enroll. Total program costs would be \$1.2 billion. Revenues would be about \$1.1 billion, assuming employers contribute, leaving a funding deficit of \$53 million. However, if employers do not contribute, the funding deficit would be about \$677 million in 2007/2008.

The people enrolling in the program using this premium would tend to be older people where the cost of private insurance is higher. This reflects the use of age adjusted premiums in the non-group market under the Commission's proposal. Thus, the \$225 PMPM premium is generally less than what older people are paying for non-group coverage.

4. Program Impacts with Enrollment Controls

One approach to fully funding the program would be to limit enrollment of people in older age groups on the basis of age. The program would effectively create waiting lists for program enrollment for each age group. In *Figure 30*, we present our estimates of the proportion of people in each age group who could be admitted to the program without experiencing a funding shortfall (i.e., assuming the employers contribute). Under the scenario using the 8.1 percent of income premium, the program could be fully funded by admitting only 90 percent of applicants age 35 to 44, 80 percent of applicants age 44 to 54 and 70 percent of applicants age 55 to 64. Under the \$225 PMPM premium scenario, the program funding deficit could be eliminated by enrolling just 90 percent of applicants age 55 to 64.

Figure 30
Enrollment Controls for Optional Continuous Coverage Portable Plan in 2007/2008 (thousands)

	Premium = 8.1% Income Tax			Premium = \$225 Per Person Per Month		
	No Enrollment Limits	With Enrollment Controls		No Enrollment Limits	With Enrollment Controls	
		Allowable Enrollment Factor	Enrollment With Controls		Allowable Enrollment Factor	Enrollment with Controls
Under Age 19	168,000	100%	168,000	25,000	100%	25,000
Age 19 - 24	48,000	100%	48,000	10,000	100%	10,000
Age 25 - 34	63,000	100%	57,000	27,000	100%	27,000
Age 35 - 44	72,000	90%	61,000	35,000	100%	35,000
Age 45 - 54	75,000	85%	52,000	49,000	100%	49,000
Age 55 - 64	68,000	70%	31,000	44,000	90%	40,000
Total	494,000	84%	417,000	190,000	98%	186,000

Source: The Lewin Group estimates using the Health Benefits Simulation Model.

Figure 31 presents our estimates of enrollment and costs under the OCCPP assuming that enrollment is calibrated by age as shown. The program is fully funded in both premium scenarios assuming that employers voluntarily contribute to the program. However, if employers do not contribute, there would be a funding deficit of \$917 under the percent of income premium scenario, or \$610 under the \$225 PMPM premium scenario.

5. Long-Term Enrollment

A unique feature of the OCCPP program is that people must commit to enrolling in the program for a period of 10 years as a condition of enrollment. Thus anyone entering the program in the second year of the program would enroll with all of those who enrolled in the first year. This accumulation of enrollees would lead to increased enrollment over time. Also, the health status profile of people enrolling in the program would eventually become more representative of the general population as these people age. (i.e., Costs for a given group will typically regress to the mean over-time as some people develop health problems and as health improves for many of the sicker people in the group.)

Figure 31
Optional Continuous Coverage Portable Plan Coverage and Costs in 2007/2008 - With Enrollment Controls

	Assumes Employers Pay Into The Program a/		Assumes Employers Do Not Contribute b/	
	Premium = 8.1% Income Tax	Premium = \$225 Per Person Per Month ^{c/}	Premium = 8.1% Income Tax	Premium = \$225 Per Person Per Month ^{c/}
Enrollment (1,000s)	417	186	417	186
Program Costs (millions)				
Benefit Costs	\$1,741.4	\$1,125.2	\$1,741.4	\$1,125.2
Administration	\$18.8	\$12.2	\$18.8	\$12.2
Total Costs	\$1,760.2	\$1,137.5	\$1,760.2	\$1,137.5
Revenues and Offsets (millions)				
Premium	\$486.4	\$503.0	\$486.4	\$503.0
<i>Employer Contribution</i>	<i>\$917.2</i>	<i>\$609.8</i>	<i>\$0.0</i>	<i>\$0.0</i>
Medicaid/CHP+	\$298.9	\$11.1	\$298.9	\$11.1
Other Safety Net Programs	\$14.5	\$6.9	\$14.5	\$6.9
Premium Subsidies	\$43.2	\$6.7	\$43.2	\$6.7
Total	\$1,760.2	\$1,137.5	\$843.0	\$527.7
Net Program Costs/(Savings) in millions				
Net Program Costs	\$0.0	\$0.0	\$917.2	\$609.8

a/ Assumes employers pay into the program what they currently contribute to employee premiums.

b/ Assumes some employers drop coverage and do not contribute to the program.

c/ Assumes a premium equal to half of the cost of coverage in the program.

Source: The Lewin Group estimates using the Health Benefits Simulation model (HBSM)

Unfortunately, time did not permit us to develop a model of enrollment and costs under the program that reflect expected growth in enrollment and the aging of the population covered under the program. Also, there are little data available on how the decision to enroll would be affected by the requirement that people remain enrolled for at least 10 years. These issues should be carefully studied before adopting such a program.